Book 12

PUBLIC HEALTH RESOURCE NETWORK

Engaging the Private Sector

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन
(2005-2012)

Book 12

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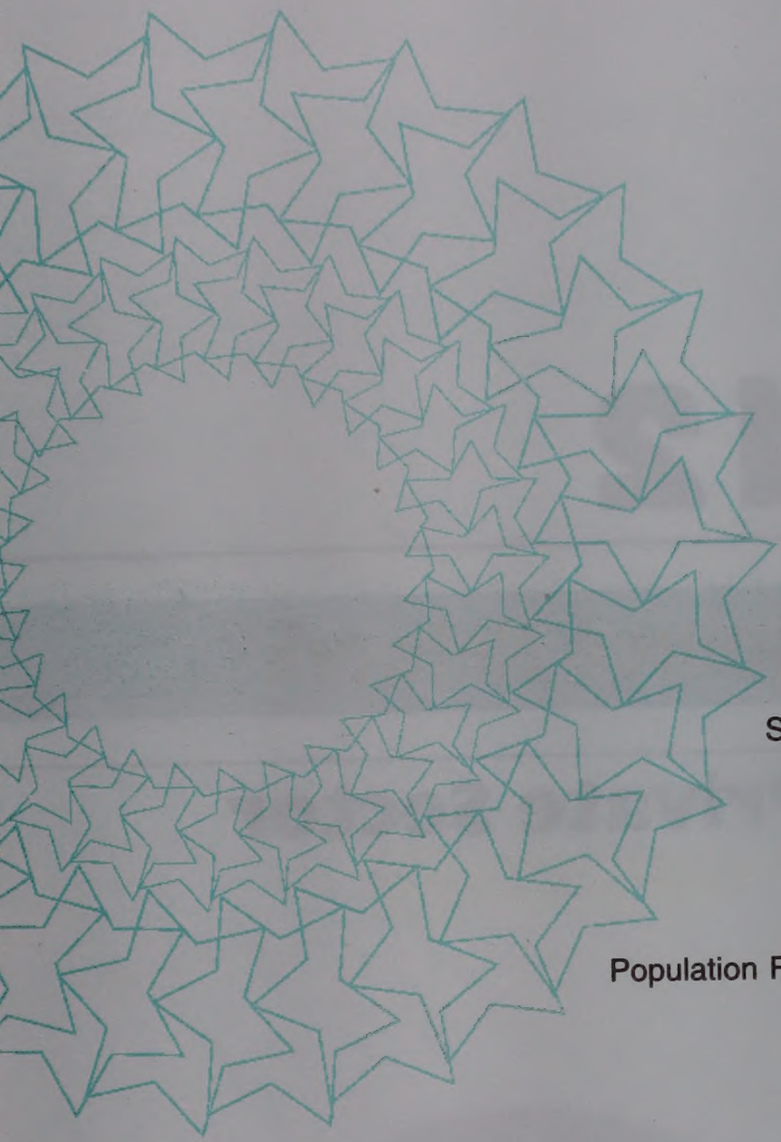
Engaging the Private Sector



Coordinating Agency

Public Health Resource Society, New Delhi

Partners

National Rural Health Mission

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Department of Health and Family Welfare, Chhattisgarh

State Institute of Health and Family Welfare Chhattisgarh

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Ajay Shah

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Contents

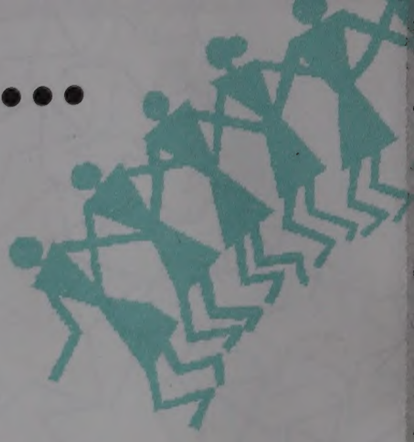
Public Health Resource Network

Preface

Public Health Resource Network (PHRN) aims to provide support to public health practitioners working in the districts in all aspects of district health planning and public health management. The central element of this initiative is a capacity building effort structured as a distance learning programme. This distance learning programme is not a substitute to formal professional public health training and it does not carry with it any guarantees of increased employment or career options. It is meant to support individuals and organizations both within and outside the health department who are committed to working for a more equitable and effective public health system. This programme complements official training and education programmes through an open-ended, more informal and immediate reaching out with information, tools and a diversity of programme options and perspectives.

The Health Mission needs a combination of dedication and professionalism, where being a professional is not one more form of privilege- but a competence that anyone willing to put in the time and effort — and a little expense— can acquire!! Thus the contact programmes at district, regional and state level would evolve into mechanisms of sharing of resources, and building mutual solidarity amongst those who work for change. The immediate context is the National Rural Health Mission. But hopefully the voluntary network that emerges will contribute over the years to the evolution of a network of district and block level resource groups who provide technical support to all efforts at decentralized planning and decentralized governance and to all societal efforts towards an equitable and just society.

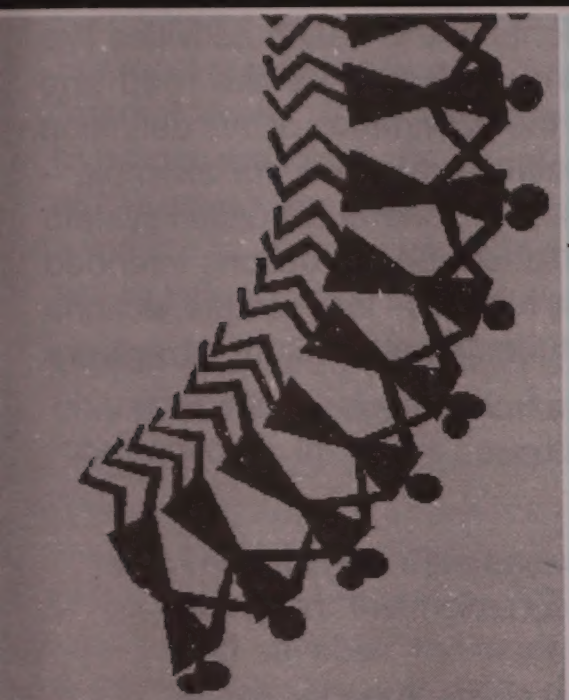
This book, the twelfth book in the PHRN series, aims to examine the various ways in which the public health system may and does seek to engage with the private sector.



While the private sector has always existed as a major player in the provision of health care services, it is very recent that a formal engagement has been attempted by the public sector with it; statedly, in an effort to provide better services for public good. Various experiments have been tried within the NRHM to varying degrees of success. This book attempts to delineate, using various examples, the terms on which such engagement can hope to be successful for the good of disadvantaged people, the types of 'partnerships' that exist, and the various models that can be attempted in the future. It also covers to some extent, the different models of health care financing, since these are often premised upon different models of health care delivery that engage with the private sector. In other words, you will find much that is currently known about the famous 'PPP' element of NRHM and also find yourself able to analyse them on grounds of cost effectiveness, satisfaction of public interest etc as you go through this module. we also hope the book will provide you with enough insight and information to fashion such PPPs as are genuinely useful to poorer people and retain the valuable consideration of equity and people's control when it comes to creating such partnerships at the district level, for example, through the Rogi Kalyan Samitis.

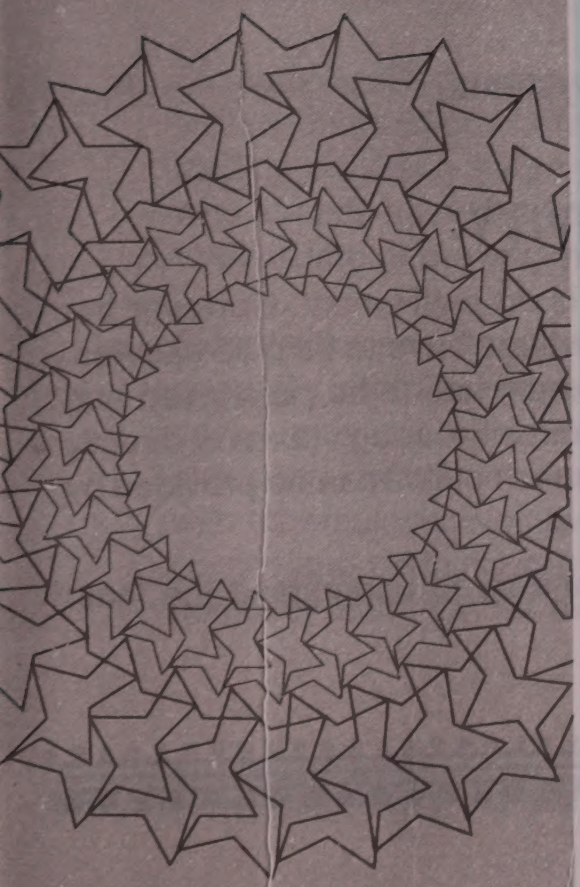
Lesson ONE

Health Care Financing : Overview



In this lesson we shall discuss:

- Role of health care financing in a health system.
- Components and functions of health care financing.
- Health care financing models.
- Health financing and expenditure in India.



BACKGROUND

The World Health Report 2000 defines a health system to include all the activities whose primary purpose is to promote, restore or maintain health. Formal health services, including the professional delivery of personal medical attention, are clearly within these boundaries. Traditional public health activities like health promotion and disease prevention, and other health enhancing interventions like road and environmental safety improvement, are also part of the system. Beyond the boundaries of this definition are those activities whose primary purpose is something other than health – education, for example – even if these activities have a secondary, health-enhancing benefit. Hence, the general education system is outside the boundaries, but specifically health-related education is included. So are actions intended chiefly to improve health indirectly by influencing how non-health systems function– for example, actions to increase girls' school enrolment or change the curriculum to make students better future caregivers and consumers of health care.

The three fundamental objectives of health systems are the following

- Improving the health of the population they serve.
- Responding to people's expectations.
- Providing financial protection against the costs of ill-health.

To achieve these objectives health systems have four different categories of tasks: The best recognized is service provision and in this we could include curative, as well as preventive and promotive tasks. Another is raising resources and allocation of resources to pay for service provision- the area of health financing. A third is resource creation – which would include the area of creation of infrastructure, equipments as well as the development of the necessary human resources. And a fourth is the stewardship role which includes regulation of the private sector, shaping the growth of the health sector and its institutions etc.

In this book we study the health care financing aspects of health systems.

HEALTH CARE PROVISION AS ECONOMIC ACTIVITY:

Health is a basic human right and the access to health care services is an entitlement. However the provision of health care activity is also an economic activity. Service providers have to be paid salaries. Drugs have to be produced and sold. Buildings have to be built. Equipment has to be purchased and replaced. People who use health services pay for these services either indirectly through taxes or directly as fees or insurance premiums. The cost of services will determine how much of this can be provided by the public sector or accessed in the private sector.

In this section we look at health care provision as economic activity and try to understand the main

issues as regarding financing health care. While studying health as economic activity, we need to recognize that "health" is a different type of commodity from other goods and services traded on markets. Understanding these features helps in setting goals, objectives and analyzing the impacts of health financing policies on different socio-economic sections of society.

For most commodities on the market, supply and demand and the prices are influenced by what is called "market forces." Thus if tomatoes are in demand and supply is far short it, prices would go up and if the tomatoes are too costly, people would not buy much and prices would have to come down to ensure that all the stocks are sold. This could be said to apply not only to goods but also to services. Thus if we need a mason to work on a building or a good tailor to stitch our clothes, to a large extent the market forces would influence the price of services in relation to supply and demand.

Health and health services are different, and do not behave like other commodities. Its special characteristics make the market intrinsically imperfect as a system for health care delivery. Government intervention is therefore essential. Let us understand how health care differs from other commodities:

- The inherent differences between health care and other commodities arise due to uncertainty about (a) "the incidence of disease" and (b) "the efficacy of treatment." For most other products and services, those who are buying the products have largely adequate information and this allows for competition between different providers. In health care there is a significant dearth of information to 'consumer' and the consumer is dependent upon a more informed interlocutor; the health care professional, for exerting a market choice. i.e., to put it simply – the patient does what the doctor orders; the doctor cannot be easily questioned; the doctor is more powerful in exerting market choices 'on behalf' of the patient than the patient herself, and finally, the doctor is not just an objective advisor, but a part of the market herself...Further even doctors have inadequate access to product information and even clinical information- as the major companies which make goods and provide services have an undue influence over even the generation and dissemination of knowledge.

- Similarly health insurance faces problems that other types of insurance do not. There is a lack of perfect information about the specific risks faced by individuals, which means companies could land up providing insurance only to those who have a much higher risk of disease or even those who already have the disease. Further the moment one gets insurance coverage, the tendency to consume or provide more health care than is needed increases.

- Externalities provide another traditional argument for government intervention. Sometimes activities generate benefits and costs that are not reflected in the benefits and costs of the firm. In these cases, individuals can and do buy an intervention and benefit from it, but they cannot prevent non-consumers from also deriving some benefit. For example if one treats and cures a patient with tuberculosis, we have prevented tuberculosis in roughly ten persons- but the latter is never costed and certainly never paid for by those ten- unless the government sees this benefit on behalf of them. Or, for example, if a row of houses is connected to the sewerage system, than

that row benefits from increased hygiene and waste management. But the entire colony benefits due to reduced flies and mosquitoes and the latter is never costed and never paid for by others.

- Public goods are goods or services such that one person's consumption does not reduce the amount available for others to consume. Typically these are goods from which consumers cannot be excluded .Since people can consume such goods without having to pay for them; no one will produce them for sale to individual consumers. Therefore they will be produced only if government pays for their production. Control of disease vectors and protection of food and water safety are examples of public goods in health. Individual action may be ineffective costly or virtually impossible.

- The need for health care is sporadic and unpredictable, so it is hard to ensure that you have the money to pay for it when it is needed .Health care can also be very expensive, particularly in the case of hospital treatment, accidents and long-term illnesses. Preventing individuals from falling into poverty because of catastrophic medical expenses and protecting and improving the health status of individuals and populations by ensuring financial access to essential public and personal health services provide a strong basis for public intervention in financing health systems. Ensuring financial protection and promoting equity requires a specific government policy focus that ensures that persons are able to access health care irrespective of the ability to pay, and prevents individuals from falling into poverty as a result of catastrophic medical expenses.

It was Shanti's first pregnancy. Both she and he husband were agricultural workers and they earned about Rs 70 rupees per day when they went to work. Shanti had not been going now for last three months. Even if she was ready to go no one was willing to give her work. Her husband got work only about 100 days in a year. And this season there was little work.

Shanti had decided to have the delivery conducted in the nearby primary health center, since the care there was of good quality. The family had quietly saved up two thousand rupees for the functions and sweets to celebrate the coming of the child. However when labour started and they went to the primary health center, after watching for a couple of hours the doctor said there was a danger of child getting affected and they should take her to the nearest hospital. A taxi was arranged and she was shifted to a private nursing home. Here they informed the family that both mother and child's life was at risk and they had to do a Cesarean section, but they needed a down payment of Rs 10,000 before they would operate. When they discharged the mother and child eight days later the bill had climbed to 30,000 rupees and they had to borrow at 50% interest rate from the local moneylender. They were members of the local self help group, but that could lend only Rs 5000. One year later they are still repaying the money-lenders loan who is threatening to seize their property, and they have been pushed out of the self help group since they have defaulted on the repayment.

This is a common situation. What could have been done so that such a situation does not occur?

HEALTH FINANCING FUNCTIONS

Health financing has been defined as the raising or collection of revenue to pay for the operation of the health system. Health financing provides the resources and economic incentives for the operation of health systems and is a key determinant of health system performance in terms of equity, efficiency and health outcomes. Health financing involves the basic functions of revenue collection, pooling of resources and purchase of interventions. These functions often involve complex interactions among a range of players in the health sector and policies concerning these functions influence the functioning of the health sector.

Revenue collection: It is defined as the way in which health systems raise money from households, businesses and external resources. There are five broad categories of health care financing, namely,

1. general revenue (taxation);
2. social health insurance;
3. voluntary or private health insurance;
4. out-of-pocket payments;
5. internal donations.

Most high income countries- like the European countries, Canada, and Australia etc. rely heavily on either general taxation or mandated social health insurance contributions. In contrast, low income countries depend far more on out-of-pocket financing. This means that individuals and families purchase health care by paying from their own personal accounts. Revenue-raising capacities increase as country incomes increase. This is because in richer countries there is a greater ability of individuals and businesses to pay, and there is better tax administration.

Risk Pooling : 'Risk pooling' is defined as 'the practice of bringing several risks together for insurance purposes in order to balance the consequences of the realization of each individual.' We do not know and can never know when any given individual will face a risk that requires a large expenditure of that family. However the number of individuals in a large group who will fall ill and require such expenditure can be better estimated. One can therefore pool resources over a large group in which each person pays a small amount regularly. When a small percentage of this group needs to spend larger amounts on health care, the money is made available from the pool. Thus, the risk for a small number of persons of having to pay a large amount is divided up into a small amount over a large population.

Risk pooling and pre-payment are critical for providing financial protection. Pooling deals with the accumulation and management of revenues so that members of the pool share collective health risks, thereby protecting individual pool members from large unpredictable health expenditures. Pooling is traditionally known as the "insurance function" within the health system, whether the insurance is explicit (people knowingly subscribe to a scheme) or implicit (as with tax revenues). If people voluntarily pay out of their incomes towards such a pool, this payment is also seen as part of out-of-pocket expenses, though it is a pre-payment.

Purchasing : Purchasing is the process by which payments are paid to providers in order to deliver a specified or unspecified set of health interventions. A variety of arrangements exists:

* Some national health services and social security organizations provide services in publicly owned facilities where staff members are salaried public employees.
* Sometimes individuals or organizations purchase services through direct payments or through contracting arrangements from public and private providers.
* Other arrangements combine these approaches.

Purchasing uses different instruments for paying providers. For example the individual or organization can directly pay the individual private provider or they could pay a hospital or health management organization which would employ and then pay the service provider or they could pay a third party a sum in advance which would pay the health management organization. The payment can be made as reimbursement for expenses incurred on treatment with or without a ceiling of how much would be paid per user. Or the payment would be part of an agreed upon budget in return for an agreement that the users would be provided with a package of services. There are many variations of these options. Resource allocation and purchasing procedures have important implications for cost, access, quality, and consumer satisfaction and efficiency gains. (The amount of health gains for a particular level of expenditure).

The organization of these functions – of revenue collection, of pooling and of purchasing - in various nations differs and the choices made depend on the goals and objectives of any health financing system. The most common goals are the following

- Raising *sufficient and sustainable revenues* in an efficient and equitable manner to provide individuals with both a basic package of essential services and financial protection against catastrophic financial losses caused by injury or illness.
- Ensuring the *purchase of health services* in an allocative and technically efficient manner.
- *Fairness (equity) of the revenue collection* mechanisms to finance the systems. Health systems should try to ensure that the poor have access to health systems and that they are not paying disproportionately for them.
- Managing revenues to equitably and efficiently *pool risks*. Financing systems should therefore aim also to pool risk between different members of the community, so that those with low health needs can subsidize those with high health need.
- Provision of financial and physical access to services including *equity* in access. Health is a basic need, and health systems should therefore aim for the highest access possible to appropriate health care services by all members of society.

Fairness in financial contribution : A health system is considered to be ***fairly financed*** if the ratio of contribution of each household to its ability to pay is identical for all households, independent of the household's state of health or use of health systems.Fair financing in health systems means that the risks each household faces due to the costs of the health system are distributed according to ability to pay rather than to the risk of illness: a fairly financed system ensures financial protection for everyone. A health system in which individuals or households are sometimes forced into poverty through their purchase of needed care, or forced to do without it because of the cost, is unfair .Fair financing deals with whether funds are raised through progressive collection mechanisms and protection of catastrophic health expenditure directly linked to the household's capacity to pay. WHO defines health expenditure as "catastrophic" whenever it is greater than or equal to 40% of the capacity to pay (total household non-subsistence effective income).In a fairly financed health, the risks each household faces due to the costs of the health system are distributed according to ability to pay rather than to the risk of illness: a fairly financed system ensures financial protection for everyone. A health system, in which individuals or households are sometimes forced into poverty through their purchase of needed care, or forced to do without it because of the cost, is unfair.

HEALTH FINANCING AND DELIVERY MODELS

1. State funded systems (Tax-Based Funding)

State-funded health care systems constitute the most widespread health financing mechanism around the world. Health specialists in the West who trace the acceptance of this to the Beveridge report published in 1942, call this "Beveridgean systems". For the erstwhile socialist countries and the present day socialist countries like Cuba, it a basic credo of socialism and they would trace its origins back to the Jacobin stream of the French revolution. General government revenues represent the main source of health care expenditures in 106 of 191 countries belonging to the WHO. In high-income countries, two-thirds of public health expenditures are funded by general revenues; in middle-income countries, almost three-quarters; and in low-income countries, virtually all public health expenditures come from general revenue. Tax-based funding has the advantage of pooling risks over a large group which increases access and also reduces operating costs. It can also be progressive- which would mean that taxes take proportionately more from the richer in society and services are used proportionately more by the poorer. These systems usually have three main features. First, their primary funding comes from general revenues. Second, they provide medical coverage to the country's entire population. Third, their services are largely delivered through a network of public providers.

ADVANTAGES	DISADVANTAGES
• Comprehensive (Universal) coverage of population regardless of individual health status income or occupation	• Unstable funding: Since tax based systems are financed from the general budget, the amount of funding available depends political priorities and ministries of health have to compete with other sectors for the same resources.
• Large scope of raising resources since tax-based systems rely on a broad revenue base of tax and non tax revenues.	• Although tax-based health systems are supposed to provide universal coverage, in most middle and low income countries they tend to benefit richer sections of the society.
• Being single pool organizations give scope for cost control and administrative efficiency.	• Lack of allocative and technical efficiency in financing and service delivery. Problems of governance and management can lead to poor quality of care and uneven access.

The United Kingdom and the Scandinavian countries are examples of such systems. So too is Cuba. In India, the public health system is based on this principle, but the coverage is so incomplete that almost 80% of health financing occurs outside this- as out of pocket expenditure.

2. SOCIAL HEALTH INSURANCE

Social health insurance (SHI) is a mechanism for financing and managing health care through pooling of health risks of its members on the one hand, and the financial contributions of enterprises, households, and the government, on the other. It is generally perceived as a financial protection mechanism for health care, through health risk-sharing and fund pooling for a larger section of the population. Social health insurance is distinguished from general revenue-funded systems by the presence of independent or quasi-independent insurance funds, a reliance on compulsory earmarked payroll contributions, and a clear link between these contributions and a set of defined rights for the insured population. Social health insurance systems have been established in more than 60 countries, beginning with Germany (Bismarck Model) at the end of the nineteenth century. Social health insurance is particularly widespread among many western industrial nations , but is also in use in developing countries, mainly in Latin America and to a lesser extent in other parts of the world.

The major features of social insurance schemes are the following

(1) Compulsory or mandatory membership of individual or groups of individuals.

(2) Responsibility at the members for payment of the regular income-related contributions or flat-rate contributions, with added contribution from employers and the Government.

(3) Contribution according to the ability to pay and not related to health risks of individuals, households or employment groups.

(4) Establishment of appropriate collection mechanisms for collecting regular contributions.

(5) Choice of health care according to the health needs (basic benefit packages are usually pre-set and the schemes allow the members to make co-payment and also to purchase supplementary health care services).

(6) Solidarity across the population; risk equalization and cross subsidization.

(7) Arrangement for social assistance to cover vulnerable populations.

(8) Covering a significantly large proportion of population, and

(9) Funds collected from contributions to be pooled as a single or multiple fund arrangement, administered by a quasi-independent public body.

ADVANTAGES	DISADVANTAGES
● SHI schemes are viewed as effective way to generate resources as pay roll contributions are easier to collect and ease the revenues needed from general taxes.	● Exclusion of poorest – SHI schemes usually cover formal sector employees and the poorest sections of the society usually in the informal sector are usually left out.
● Less dependence on budget negotiations and state government funding through taxation form supplementary income.	● SHI systems are complex and expensive to manage. Administrative costs are higher than tax-based systems.
● High redistributive effect.	● Generation of excess demand and high cost escalation for curative care.
● Strong population support	● Poor coverage for chronic and preventive care.

The Canadian and Australian systems are the main examples of social health insurance. Thailand is also an important example. The employee's insurance scheme in India would qualify for being called social health insurance.

3. Voluntary or Private Insurance

"Private" or "Voluntary" health insurance is a health financing model that is particularly prevalent in high-income countries as a supplement to publicly financed coverage- whether the latter is tax based or social insurance mode. Voluntary health insurance is defined as any health insurance that is paid for by individuals out of their incomes voluntary contributions. Voluntary health insurance can thus be distinguished from National Health Service systems and social insurance financing models, which are both characterized by mandated payments. Private insurance schemes usually, operate individual risk-rating, which means that a high-risk individual will be charged more to join than a low-risk individual.

Private insurance spreads risk for an individual or family, but does not pool risk on a large scale. Experiences from some developed countries suggest that it helps to increase service capacity and innovation and helps to finance health services which are not covered publicly. In countries where access to health services for all is a social priority, private insurance is likely to remain a small supplementary source of income, rather than the main one. Private insurance requires effective regulation to ensure that consumers are protected and that companies are financially sound. The regulation and accreditation could be carried out by the Ministry of Health, or other public body, such as the Ministry of Finance. Close monitoring of provider practices and prescribing are also needed to control cost escalation. Further availability of private/voluntary insurance has not reduced financial barriers to access care and in many countries it has increased differentials in access to health care. In addition, the 'transaction costs' (administration, contracts, monitoring etc.) are generally high - between 10 and 50%, according to a number of studies, and this compares with 5-10% for social health insurance programmes.

4. Community based health insurance(CBHI)

CBHI can be defined as a non-profit type of health insurance for the informal sector, which is formed on the basis of an ethic of mutual aid and the collective pooling of health risks. Typically, members participate in the management of CBHI schemes. CBHI schemes share the goal of finding ways for communities to meet their health financing needs through pooled revenue collection and with resource allocation decisions made by the community. CBHI schemes allow members to pay small premiums on a regular basis to offset the risk of needing to pay large health care fees upon falling sick. Unlike many private voluntary insurance schemes which are planned as a commercial enterprise, CBHI schemes are typically based on the concepts of mutual aid and social solidarity.

In many low-income countries, community-based health insurance plays an increasing role in providing medical coverage to populations without access to other forms of formal medical protection, such as

social health insurance or private insurance. Community-based health insurance is part of an overall health financing strategy in a number of countries, given the high out-of-pocket financing of care, the uncertainty surrounding anticipated financial flows from donors, the large rural and informal sector populations, and the weak capacity of governments to raise taxes. Community-based health insurance is found throughout the world, but it is particularly prevalent in Sub-Saharan Africa, China, India, Nepal, and the Philippines, and in Latin America in Argentina, Colombia, Ecuador, and Mexico.

ADVANTAGES	DISADVANTAGES
● Provision of better access to health care in low income settings.	● Ability to generate resources is limited due to the small size of risk pool
● Provides financial protection and reduction in the out-of-pocket spending of vulnerable population.	● Small risk pool, adverse selection and lack of management skills affect the financial sustainability of schemes.
● Helps in mitigating the gaps arising out of insufficient provision of public health services.	● Possibilities of scaling up CBHI schemes are very limited.

Examples are the SEWA- rural health insurance programme in Gujarat, the RAHA programme run by missionaries in northern Chhattisgarh, the ACCORD health insurance programme in Tamil Nadu and so on.

4. Fee-for Service (Out-of-Pocket)

Direct payment (Fee-for-service) or out-of-pocket expenditures are the predominant form of health financing mechanism in most less and medium developed countries. Out-of-pocket expenditures are defined as any direct outlay, including gratuities or in-kind contributions that households make for services and goods from health practitioners, pharmacists, medical supply vendors, and others. Out-of pocket spending accounts for 93 percent of total private health spending and more than 60 percent of total health spending in low-income countries. Direct payment systems share a number of features. One is that individuals have a direct incentive to look after their own health. Theoretically, since they are unlikely to use services 'frivolously' as could happen with insurance based care, this should reduce inflation of health care costs. But in practice when individuals have to deal with providers directly their ability to negotiate is limited and given their lack of information about their health care needs and its costs, they land up paying whatever is asked of them. Therefore problems of equity and access to services are

much more with a system financed through direct payments, unless the state is able to finance contributions for disadvantaged groups and also regulate the costs of the private sector provider. None of the direct payment systems pool risks to any large extent, though some do spread risks over time, by deferred payments. Out-of-pocket spending normally tends to be regressive in nature and does not guarantee universal access to health services.

Out-of-pocket payments for health can cause households to incur catastrophic expenditures, when serious illness in encountered and hospitalization and surgery become needed. This in turn can push them into poverty. When people have to pay fees for health care, the amount can be so high in relation to income that it results in "financial catastrophe" for the individual or the household. Such high expenditure can mean that people have to cut down on necessities such as food and clothing, or are unable to pay for their children's education or have less ability to bear a crop failure or a loss of employment. Every year, approximately 44 million households, or more than 150 million individuals, throughout the world face catastrophic expenditure, and about 25 million households or more than 100 million individuals are pushed into poverty by the need to pay for services. In India a large number of farmer suicides are correlated to the link between high health expenditures which leads to decreased ability to withstand set -backs in agricultural operations.

TRENDS AND PATTERNS IN HEALTH SYSTEM FINANCING

Health expenditure is highly unequal across the globe. Health expenditure as share of GDP increases as income increases, from around 2-3% to a typical level of 8-9% .Table 2.1 shows that in health expenditure, both in terms of "percentage of GDP spent on health" and in "per capita health expenditure," it is much higher in the developed countries, and there is a very wide variation of per capita health expenditure across countries. It is typically extremely low in developing countries compared with most of the developed countries the health financing profiles changes as countries moves to different stages of income spectrum. In less developed countries almost half of the health spending is out of pocket expenditure and government, through the ministry of health provides basic public health and other services. Social insurance is limited due to small size of formal sector and community based experiments are available to varying degrees. The share of out-of-pocket expenditure accounts for around 40% of all health spending in Middle Income Countries, and social health insurance systems are also well developed in many of these countries. Countries in higher income group with improved institutions and greater revenue raising capacity, in most cases have publicly financed universal coverage or publicly mandated private coverage.

Health care financing system trends by country income level.

Low-Income Countries	Middle-Income Countries	High-Income Countries
Patient Out of Pocket	Private Insurance	Patient Out of Pocket
	Patient Out of Pocket	

Social Insurance	Social Insurance	National health insurance model
Government Budget	Government Budget	Private health insurance model
Community financing		

The pattern of health expenditure across the WHO member state shows a higher ratio of public health spending to private spending in developed countries with few exceptions. By contrast, in middle developed and low developed countries, either private expenditure dominates or there is very little difference between the shares of private and public expenditure, although in general both tend to be low. In many poor countries total health spending is very low, even compared to the cost of a package containing only a shortlist of highly justified interventions. Public expenditure on health is particularly important in poor countries for assuring that public goods and services with large externalities are adequately provided. However, these are generally the countries with the lowest relative public spending in health.

HEALTH EXPENDITURE AND HEALTH INDICATORS IN SELECTED COUNTRIES

HDI Rank	Country	Health Exp as %of GDP		Per capita exp on health (PPP US $)	Out-of-pocket exp as % of Private Exp (2001)	Life Expect-ancy at Births (2001)	IMR Rate (2001)	Per capita GDP $ (2001)
		Public	Private					
1	Norway	6.9	1.2	2,920	96.8	78.7	4	36974
2	Iceland	7.6	1.6	2,643	55.2	79.6	3	27032
3	Sweden	7.5	1.3	2,270	100	79.9	3	23680
4	Australia	6.2	3	2,532	59.6	79	6	19054
7	U S A	6.2	7.7	4887	26.5	76.9	7	34946
8	Canada	6.8	2.8	2,792	52.3	79.2	5	22385
9	Japan	6.2	1.8	2,131	74.9	81.3	3	32540
11	Denmark	7	1.5	2,503	90.8	76.4	4	30265
13	U K	6.2	1.4	1989	55.3	77.9	6	24186
18	Germany	8.1	2.7	2,820	42.4	78	4	22418
21	Italy	6.3	2.1	2,204	82.1	78.6	4	18928
25	Cyprus	3.9	4.3	941	98	78.1	5	11566
52	Cuba	6.2	1	229	76.8	76.5	7	2234
55	Mexico	2.7	3.4	544	92.4	73.1	24	6150
58	Malaysia	2.1	1.8	345	92.8	72.8	8	3748
65	Brazil	3.2	4.4	573	64.1	67.8	31	2888
64	Colombia	3.6	1.9	356	65.2	71.8	19	1924
86	Maldives	5.6	1.1	263	100	66.6	58	1947
88	Georgia	1.4	2.2	108	99.7	73.4	24	601
96	Turkey	3.6	1.5	294	98.8	70.1	36	2131
99	Sri Lanka	1.8	1.9	122	95	72.3	17	849
104	China	2	3.4	224	95.4	70.6	31	918
112	Indonesia	0.6	1.8	77	91.8	66.2	33	678
109	Vietnam	1.5	3.7	134	87.6	68.6	30	413
120	Egypt	1.9	2	153	92.2	68.3	35	1425
127	India	0.9	4.2	80	100	63.3	67	462
131	Myanmar	0.4	1.7	26	99.6	57	77	1027
139	Bangladesh	1.6	2	58	93.2	60.5	51	332
143	Nepal	1.5	3.6	63	93.3	59.1	66	231
144	Pakistan	1	3	85	100	60.4	84	401
140	Congo	1.4	0.8	22	100	48.5	81	777
163	Zambia	3	2.7	52	71.8	33.4	112	344
165	Chad	2	0.6	17	80.9	44.6	117	198
169	Ethiopia	1.4	2.1	14	84.7	45.7	116	93

Source: World Health Report 2003, Human Development Report 2003 & UNTCAD Report 2002

HEALTH FINANCING IN INDIA

Health care system in India is pluralistic in nature with financing and provision done by both government and private sector. The government agencies include various departments of central, state, union territories and local governments and various pubic sector enterprises. These agencies provide health care through public hospitals or by reimbursing for treatment in private facilities for certain sections of the population. These are financed through tax and non-tax revenues of the government or through revenues of the public enterprises. The government acts as an agent for social insurance and also partly finances social insurance schemes available to certain sections of employees. Private providers include private hospitals, clinics and pharmaceutical companies which are financed through fee for service; private and social insurance financed through individual or company premiums; and certain community initiatives financed from contributions from both government and private households and external aid.

According to the National health accounts of India 2001-02, health spending is estimated to be in the range of 4.5% to 6% of the GDP. Of the total expenditure, 20.3 percent was public expenditure, 77.4 percent was private expenditure and remaining 2.3 percent external support. According to the Report of the National Commission on Macroeconomics and Health, 2005, households undertook nearly three-fourths of all the health spending in the country. Public spending was only 22 per cent, and all other sources- which includes insurance and not for profit agencies, would account for less than 5 per cent. State wise analysis of health expenditure reveals that Kerala accounts for the highest household spending in India, followed by Haryana and Punjab. In States such as UP, MP and Orissa, both public expenditure and private expenditure is relatively low.

Review Questions

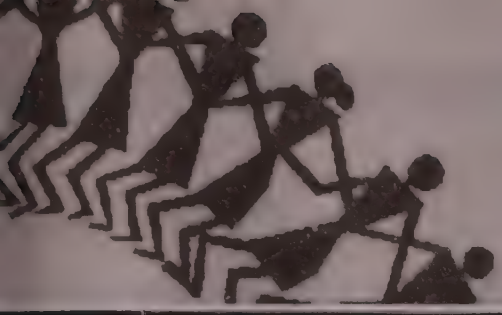
1. How is health care as a 'commodity' different from other commodities?
2. What are the various ways in which health care can be financed?
3. What does risk pooling mean?
4. What are the trends in the use of these methods of financing in developing countries such as India?
5. What are the characteristics of an 'equitable' health financing system?

Application Questions

1. What do you suggest is the ideal health financing route for India? Support your view with arguments.
2. Describe in detail any one insurance scheme giving its pros and cons.

Project Work

1. Do a case study of a poor family that has suffered catastrophic health expenditures. How could this have been avoided?
2. Provide a case study of a positive community or state intervention in saving a family from health expenditure related catastrophe.

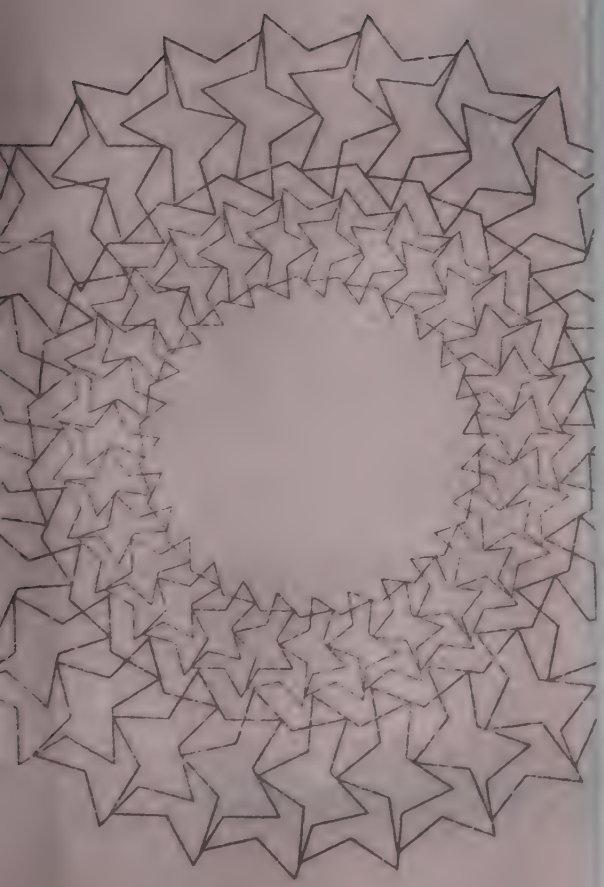


Lesson TWO

Community Risk Pooling & Health Insurance

In this lesson we shall discuss:

- The role of risk pooling and insurance in health care.
- Types risk pooling arrangements in India.
- Community financing arrangements for informal sector.
- Components of a health insurance scheme.



INTRODUCTION

Insurance provides the means by which risks of uncertain events are shared between people. Premiums are paid to an insurance institution by those potentially at risk. The insurance institution compensates any insured victim of the event for any financial loss resulting from the event. Insurance therefore helps to lessen and spread risks and it relies on the fact that what is unpredictable for an individual is highly predictable for a large number of individuals.

Health insurance rests on three grounds, that illness cannot be predicted, hospitalization costs cannot be planned and the proportion requiring hospitalization in any large population is small and therefore permits risk pooling. Health insurance essentially tries to minimize uncertainty of illness and uncertainty of being able to bear the cost of treatment. Legally insurance is defined as the contract between insurer and the insured, in which the insurer agrees to indemnify (compensate) the insured in lieu of payment of premium, for any financial loss due to risks covered in the policy.

In simple terms health insurance is sharing of risk between the sick and non sick population by the means of pre-payment and pooling resources such that in anticipation of adverse health events the cost of health care is borne by all the members of the pool. If all the members are of the same income group and have similar risk of illness, then it is a horizontal sharing of risks. If the members of the group are from different income levels then in addition to the above the higher economic group with less disease would share in the costs of the rest and thus reduce their costs. Similarly those who are economically active and young and less likely to get disease reduce the economic burden of disease of the elderly and the very young.

HEALTH INSURANCE SCENARIO IN INDIA

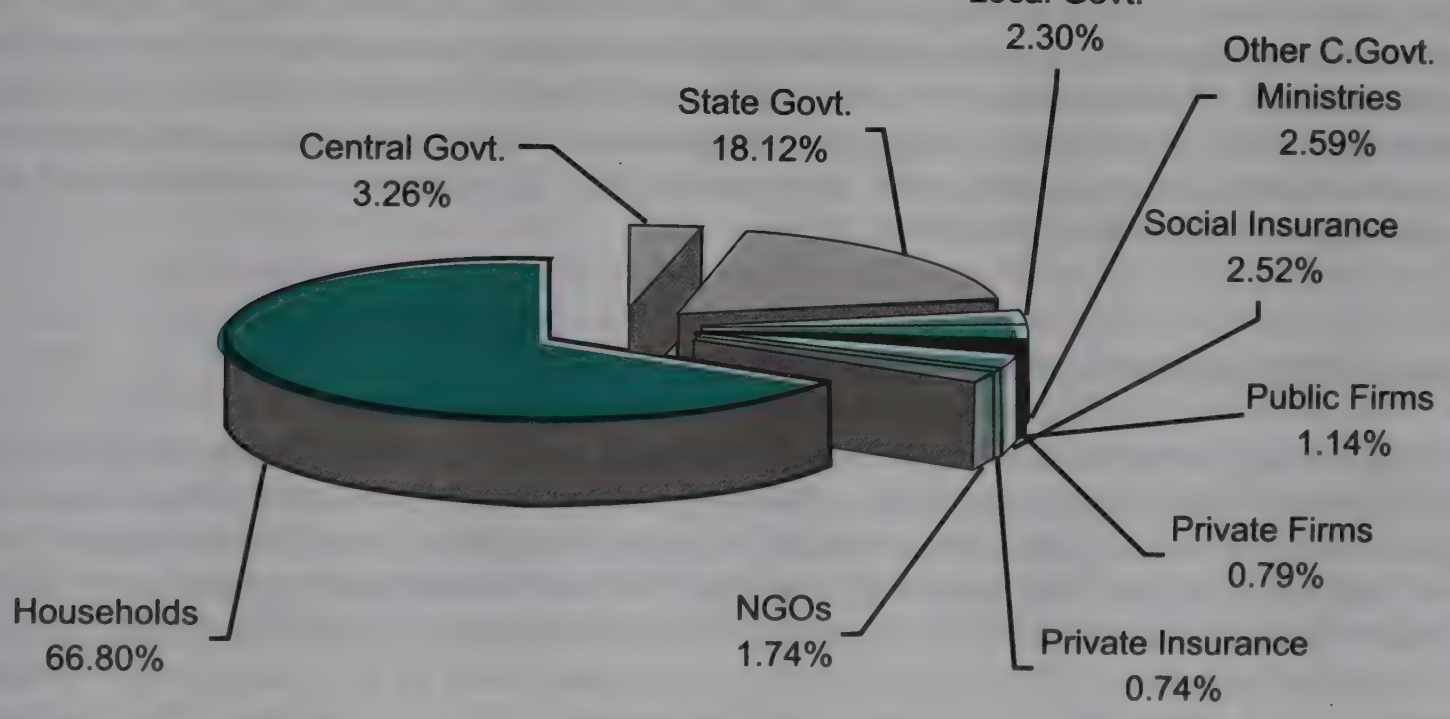
There are a wide variety of health insurance schemes existing in India. These range from the social health insurance arrangements for organized sector to community based health insurance schemes. Based on ownership the existing health insurance schemes can be broadly divided into categories such as:

- Government or state-based schemes
- Employer provided insurance schemes
- Market-based schemes (private and voluntary)
- Community Based Health Insurance (NGO or cooperative)-based schemes

Health insurance in India health insurance is still at a very nascent stage. Social health insurance covers

about 35 million people through the Employees State Insurance Scheme (ESIC) and the Central Government Health Scheme (CGHS). These two schemes cover the formal organised industrial sector employees and civil servants. Private health insurance is limited to the corporate sector and the upper middle class and covers less than 15 million people. There are many employers who reimburse costs of medical expenses of the employees with or without contribution from the employee. It is estimated that about 20 million employees may be covered by such reimbursement arrangements. There are several government and private employers such as railway and armed forces and public sector enterprises that run their own health services for employees and families. It is estimated that about 30 million employees may be covered under such employer managed health services. Even counting those covered by employer provided services, the total number of Indians covered by any form of health security is less than 10%. Community health insurance has been emerging in the last two decades in the rural areas and has been steadily but rather slowly increasing coverage of the informal sector. Health insurance as a form of financial intermediation both social and voluntary private insurance - has extremely limited reach in the Indian context. This is clearly brought out by the insignificant share of insurance which accounted for little over three percent of overall health spending in the country.

Health Expenditure by Financial Intermediaries, 2001-02



Source: Government of India, Report of the National Commission on Macroeconomics and Health, 2005.

1. Employees State Insurance Scheme and Central Government Health Scheme

Established in 1948, the Employees State Insurance Scheme (ESIS) is an insurance system which provides both the cash and the medical benefits. It is managed by the Employees State Insurance Corporation (ESIC), a wholly government-owned enterprise. The scheme applies to power-using factories employing 10 persons or more, and non-power and other specified establishments employing 20 persons or more, with employee's earnings up to Rs 7500 per month being covered, along with their dependants. The current coverage stands at 84 lakh employees and 353 lakh beneficiaries across 22 States and Union Territories. The benefit package is quite comprehensive in its coverage of health-related expenses, going beyond the cost of medical care to include cash benefits (sickness, maternity, permanent disablement of self and dependant) as well as other benefits such as funeral expenses and rehabilitation allowance. However, the actual package of benefits available is determined more by the type of facility accessed rather than the type of cover. Medical care comprises outpatient care, hospitalization or specialist treatment as well as services of the Indian systems of medicines. These services are provided through a network of ESI hospitals, public health care centres, and non-governmental services.

Established in 1954, the CGHS covers employees and retirees of the Central Government, and certain autonomous, semi-autonomous and semi-government organizations. It also covers Members of Parliament, governors, accredited journalists and members of the general public in some specified areas. The families of the employees are also covered under the scheme. Total beneficiaries stand at 43 lakh (10.4 lakh card holders, 2003) across 24 cities with membership in Delhi being the highest. Benefits under the scheme include medical care at all levels and home visits/care as well as free medicines and diagnostic services. These services are provided through public facilities (including CGHS-exclusive allopathic, ayurvedic, homeopathic and unani dispensaries) with some specialized treatment (with reimbursement ceilings) being permissible at private facilities. Of the total expenditure, about a third is spent on wages and salaries of the CGHS staff.

2. Employer provided insurance schemes

Many corporate and public sector companies have comprehensive health schemes and health facilities for their employees. Depending on the nature of the organization, they either have their own health facilities or tie-ups with insurance companies for coverage. The workers of plantation and mining industry, railways, defence, steel industry have their own health facilities. For example all the employees and their families of the steel factories and mines that come under the Steel Authority of India (SAIL) are covered by a single insurance programme. This extends to the employees even as they become pensioners. The employees pay a premium that is deducted from their salaries. SAIL pays the rest of the premium. The health care providers are exclusively the SAIL run hospitals and where they cannot manage the case, the accredited hospitals to which they refer to. At a premium rate of about Rs 4000 per year per employee this entire workforce and their families are thus provided a very good quality of health care and the cost

of health care provision is also kept within manageable limits and managed efficiently. In the private sector again, many of the enterprises have purchased health insurance cover for their staff. However, such employer paid insurance coverage is restricted to a section of the organized sector workers nly, and most of the informal and unorganized sector workers, who form the majority of the workforce, do not have these benefits.

3. Market-based systems (private and voluntary)

While the private health insurance market in India is still relatively untapped, there has been a large increase in private insurance since the privatization Bill on the insurance sector was passed. The Insurance Regulatory and Development Bill, which was passed in Parliament in January 2000, allowed the insurance sector to open up to private players. The Insurance Regulatory and Development Authority, IRDA, is the apex body that has been created to ensure that the insurance sector operates in a manner that is in keeping with the interest of the consumers. The General Insurance Company (GIC) was converted into India's national re-insurer from December 2000, and all the four subsidiaries working under the GIC umbrella (Oriental Insurance, New India Assurance, National Insurance, United India Insurance) were restructured as independent insurance companies. The Indian Parliament has cleared a Bill on July 30, 2002, de-linking the four subsidiaries from GIC. A separate Bill has been approved by Parliament to allow brokers, cooperatives and intermediaries in the sector.

In addition to the four public sector general insurance companies and Life Insurance Corporation, India now has 15 life and 14 non-life insurers in the private sector. In addition, Third Party Administrators (TPAs) have been allowed to operate in the health insurance market to aid cashless transactions and smooth administrative functioning of the insurance market. The gross premium has increased from Rs. 9,522 crores in 1999-2000 to more than Rs. 18000 crores in 2004-05 (IRDA 2005). The health premium has shown an impressive eight-fold growth in the last five years reaching Rs. 17,232 crores in 2004-05. This statistic clearly reflects the contribution of the health segment to the overall growth of the insurance sector. While the insurance sector is growing as a whole, the health segment is contributing to this growth to a great extent. The largest share of the health insurance market belongs to Mediclaim, which is the standardized product offered by the four public sector companies, National Insurance, New India Assurance, Oriental Insurance and United India Insurance. Mediclaim was till recently, a reimbursement policy covering hospitalization and domiciliary hospitalization for a pre-specified period. There are additional features like risk (age) rated premiums, reimbursement of cost of medical check, claim free bonus, family discount etc. Mediclaim excludes pre-existing diseases, HIV/AIDS, dental problems, pregnancy related expenses.

The private insurance companies are at present only 10-15 percent of the total health insurance market. The products that they offer are similar to Mediclaim and a few companies offer comprehensive products, lumping together life and health insurance.

4. Community Based Insurance Schemes in India

In India, more than 90% of the general population and almost all poor are not covered under any health insurance schemes. In the absence of viable risk pooling and prepayment mechanisms poor household spend large proportion of their household income on treatment. It has been found that out-of-pocket expenditures for health care can be 'catastrophic' in the sense of leading to or aggravating poverty by crowding-out other essential consumption items such as food, housing and clothing and forcing the family into borrowing money at usurious (highly exploitative) rates that predominate in informal credit markets from which the poor are forced to borrow. Community financing is being recognized as an important option to reduce catastrophic illness expenditure for people in rural areas and informal sector. In India community financing experiments are limited and these programs are usually run by NGO's or non –profit organizations. These organizations rely on financing from various sources, including government, donor agencies community and self generated sources. They are planned to benefit primarily workers and families of informal sector and rural population by contributing to the resources available for local health care systems, be it primary care, drugs or hospital care. This ranges from tribal populations (ACCORD, Karuna Trust, and RAHA), dalits (Navsarjan Trust), farmers (MGIMS, Yeshasvini, Buldhana, and VHS), women from self help groups (BAIF, DHAN) and poor self-employed women (SEWA). The size of the target population ranges from a few thousands to 25 lakh (Yeshasvini trust).Currently, there are about 52 CBHI /Micro Insurance programmes in India, initiated and administered by NGOs. Of these, 25 schemes came up during the last four years alone. Most insurance schemes (66 per cent) are linked with microfinance services provided by specialised institutions (16 schemes) or non-specialised organisations (15 schemes). Health care providers implement only 12 per cent of the schemes. Around from 5 to 6 million poor individuals are covered for various health risks through such schemes. In many schemes, the community is also involved in various activities such as creating awareness, collecting premiums, processing claims and reimbursements, and the management of the scheme (deciding the benefit package, the premiums, etc).

Community Based Health Insurance in India can be categorized into three types based on their structure and features.

- Type I (Provider model)—the provider of health care plays the dual role of providing health care and running the insurance programme (e.g. ACCORD, VHS,). Here the NGO hospital provides health insurance for the target population. Those who join pay a premium to join and if and when they fall sick the provider who is also the insurer provides care for them at reduced rates.
- Type II (Insurer Model)—where a voluntary organization/NGO is the insurer, while purchasing care from independent providers (e.g. Tribhuvandas Foundation, DHAN Foundation). In this model the NGO takes the role of the insurer, collects money and purchases healthcare for its members. It has an agreement with one or more providers to whom those enrolled are sent when they are in need of health care.

- Type III—(Intermediary design)—The NGO plays the role of the agent purchasing care from providers and insurance companies. (E.g. SEWA, Karuna Trust, BAIF). The NGO is neither the health care provider nor the insurer, but acts like an intermediary, like the third party administrator (TPA). In this model, NGO collects the premium, but passes it onto a formal insurance company. This company then takes the risk of running the insurance.

Characteristics of CBHI Models in India

	Provider Model	Insurer model	Intermediary model
Needs a community based organization	Not necessary	Necessary	Is beneficial if one wants to negotiate an effective package with the insurance company.
Community awareness	Necessary	Necessary	Necessary
Premium	Depends on the benefit package, usually lower than the other models as the provider has every motivation to keep health care provision costs low	Depends on the benefit package. There are usually significant exclusions in low premium situations.	Depends on the products available. Can be negotiated. There are usually significant exclusions if premiums are kept low.
Benefit package	A very comprehensive package. Usually includes outreach activities, OP and IP. But usually limited by what services the provider is already providing.	. The lower the premium or the higher the costs of treatment the smaller the benefit package. The higher the numbers insured, the larger the possible benefit package.	A standard package covering IP only. Certain aspects, e.g. the maximum limit and exclusions can be negotiated.
Fund management	Usually institutionalized and easy	Members have to be trained and supervised initially	Collection of premium needs to be supervised. Financial risk is with the company
Providers	The NGO hospital. A single provider usually.	Multiple private providers. Usually no control over them. Tendency for moral hazard (wasteful prescription and/or consumption of are) is high, especially in the intermediary model.	

	Provider Model	Insurer model	Intermediary model
Administration	Simple and shared between the institution and the community.	Complicated and the sole responsibility of the community	Simple and shared between the NGO and the company
Enrolment into the scheme	Tends to be higher as compared to the other two models		
Utilization of services	Higher as the package is more comprehensive.		Lowest among the three models.
Risk management	Is the lowest among the three models	Being flexible, they can introduce measures to control risk	Is already built into the model. But more can be done.

Source: Devadasan et al (2004)

Apart from the structure, pre-payment schemes/community based health insurance schemes in India differ in terms of amount of premium collected, coverage, benefit package and management of funds. Most of the programmes cover rural poor and the premiums range from Rs.20 to 120 per person per year. The premium is usually paid as a cash contribution once a year during a definite collection period. The benefit package of majority of schemes includes ambulatory care and inpatient care but some schemes limit it only to ambulatory care and others to only in-patient care or some sub-set of it – like only surgeries in the Yeshasvini scheme. Most schemes had important exclusions like pre-existing illnesses, self-inflicted injuries, chronic ailments, TB, HIV; etc and most of the schemes reimbursed direct costs of treatment. Community Based Health Insurance schemes often provide supplementary benefits life insurance, insurance against personal accident and/or asset insurance etc. Fund management in majority of schemes is done by the community members, or by the voluntary organization thereby keeping transaction costs low. This is done by efficient monitoring of supply of health care, influencing health behaviour through health education and designing tailor made schemes to community needs.

Notable community based health insurance initiatives in India includes Yeshasvini, Accord ,Sewa, Voluntary Health Services, Sewagram, Karuna Trust etc.

The Yeshaswani scheme is an insurance scheme for farmers designed and implemented by the cooperative department Government of Karnataka since 2002.The scheme provides financial risk protection against 1600 surgeries offered in 90 accredited hospitals at prefixed rates. It began with a modest premium of Rs 90, now revised to Rs 120 and then when it was further revised upwards, the government subsidised some of the costs Outpatient treatment associated with the surgical event is free and any diagnostic service resulting in surgery carries a discount of 50%. However the benefits package is limited to these surgeries and all conditions requiring outpatient care or any other form of inpatient care

are not covered. The monetary size of the maximum benefit package is Rs one lakh. At the point of service, the treatment is cashless with hospitals getting reimbursed by the programme organisers. This is a provider run scheme, run by the network of private hospitals. Recruitment of beneficiaries is done through their farmers and diary cooperatives. The management hires a third party administrator to make the payments and administer the programme.

The pre-payment scheme initiated by Tribhuvandas Foundation provides coverage to members of one fifth of households of more than 300 villages at a premium of Rs. 10. The benefit package includes free primary care subsidized drugs and 50% subsidy on hospital care in the foundations own hospital This small premium serves to make them aware of the services available and to use it to access primary curative care and use the hospital services.

SEWA, which operates in Ahmedabad, provides Hospitalization cover up to Rs 2000 per person to SEWA union members and their husbands. The premium ranges form Rs.22.50 for individual and Rs.45 for couples. It does not cover out-patient cost. The benefits package is very limited – and therefore it is only for short duration hospitalisation that it would help. Even then the programme needs subsidy. However this also increases access of the poor to hospitals. Many NGO programmes share these problems. They have low premiums but also a low benefits package. They are useful supplements to various voluntary programmes of the NGO, but by itself not sufficient to either give adequate health coverage or sustain the NGO on this activity alone.

The scheme initiated by Karuna trust in Karnataka covers hospitalization expenses up to Rs 2500 per person per and it also covers loss of wages. The premium per person is Rs 30 per year and is fully subsidized for the SC/ST population. This is mainly built around public hospitals.

Major Community Health Insurance Schemes in India

Name and location	Population covered of the scheme (target population in 2003)	Premium collected (per cent target population covered in 2003)	Benefit package
ACCORD Gudalur Nilgiris, Tamil Nadu	Tribes living in Gudalur taluk and who are members of the union(n=13,000)	Rs 25 per person per year (36%)	Hospitalization cover up to Rs 1500 per person per year
BAIF, Urali Kanchan Pune, Maharashtra	Women members (between 18 and 58 years) of the micro savings scheme in 22 villages (n=1500)	Rs 105 per person per year (58%)	Hospitalization cover up to Rs 5000 per person per year

Name and location	Population covered of the scheme (target population in 2003)	Premium collected (per cent target population covered in 2003)	Benefit package
BUCCS Buldhana, Maharashtra	Members of the Buldhana Urban Cooperative and Credit society(n=175000)	NA	Hospitalization cover up to Rs 5000 per
DHAN Foundation Kadamalai taluk, Theni District, Tamil Nadu	Women members of the micro finance scheme and living in mayiladumparai block (n= 19049)	Rs 100 per person per year (40%)	person per year Hospitalization cover up to Rs 10000 per person per year
Karuna Trust, Narsipur Block, Mysore District, Karnataka	BPL families in T Narsipur Block (n = 278,156)	Rs 30 per person per year. Fully subsidized for the SC/ST population (31%)	Hospitalization cover up to Rs 25000 per person per year. Includes ambulance services and loss of wages.
Raigarh Ambikapur Health Association (RAHA) Raigarh, Chhattisgarh	Poor people living in the catchment of the 92 rural health centers and hostel students. (n = 92,000 individuals).	Rs 20 per person (58%)	Primary care free and secondary health care at subsidised rates in their own hospital.
MGIMS Hospital Wardha, Maharashtra	The small farmers and landless labourers living in the 40 villages around Kasturba Hospital (n= 30,000)	Rs 48 per family of four (in cash or kind) (90%)	Hospitalization cover up to Rs 1500 per person per year
SEWA Ahmedabad, Gujarat	SEWA Union women members (urban and rural), and their husbands living in 11 Districts of Gujarat (n = 1,067,348)	Rs 22.50 per person or Rs 45 for a couple (10%)	Hospitalization cover up to Rs 2000 per person

Name and location	Population covered of the scheme (target population in 2003)	Premium collected (per cent target population covered in 2003)	Benefit package
SHADE Kolencherry, Kerala	Members of the SHGs operating in Ernakulam district (n = 9000)	The UHIS scheme (Rs 548 for a family of 5) (20%)	Hospitalization cover for family up to a maximum limit of Rs 30,000 per family per year
Student's Health Home, West Bengal	Full-time student in West Bengal State from Class 5 to University level (n= 104,247)	Rs 4per student per year (23%)	Primary and secondary health car
Voluntary Health Services, Chennai, Tamil Nadu	Total population of the catchment area of 14 mini-health centers (n= 104,247)	Rs 250 per family of five (12%)	Hospital cover
Yeshasvini Bangalore, Karnataka	Members of the District Farmer's cooperative societies and their families (n = 80 lakh)	Rs 120 per person (25%)	Cover for all surgeries up to Rs 100,000

Source: Compiled from Anil Gumber (2001), Devadasan et al (2004), NCMH 2006

A systematic review of experiences of various community financing arrangements reveals that community-based health insurance schemes have made positive contribution in terms of financial protection, resource mobilization, prevention of social exclusion, and in health care provision. The main strengths of the CBHIs schemes are that they have been able to reach out to the weaker sections and provide some form of health security, increase access to health care, protect the households from catastrophic health expenditures and consequent impoverishment or indebtedness. However in most schemes the benefits are small, there is an exclusion of poorest of poor, and there is little cross subsidization. Thus the sick poor share their risks with the non –sick poor. But there is no sharing of risk with better economic, low risk groups. Due to small amounts of revenues pooled CBHI schemes provide basic primary and some degree of secondary care and this is not enough to cover catastrophic illnesses, which is the principal cause of impoverishment. Moreover community-based schemes also tend to become too small to bargain or negotiate better terms of services from providers. Further scaling up and expansion of coverage of these schemes is a challenging task as majority of schemes depends crucially on external funding and

donor assistance.

At present several new initiatives are coming up which aim at providing comprehensive community based health insurance through public- private partnerships. The insurance regulatory and development authority (IRDA) has recently passed the Micro- Insurance Regulations 2005 that aim to promote rural insurance. The IRDA has allowed insurers to (a) issue policies with cover ranging from Rs 5,000 to a maximum of Rs 50,000 for general and life insurance, and (b) appoint self-help groups, micro-finance institutions and other NGOs to act as micro-insurance agents for the distribution of micro-insurance products under this new regulation. Potentially some of these initiatives can be tried even at a district or sub-district level.

5. Government Initiatives in Health Insurance

The central government has implemented universal health insurance scheme in 2003 and this scheme has been implemented as a community-based insurance scheme by the NGO's through the four public Sector national insurance companies. This scheme provides financial risk protection up to Rs 30,000 per annum towards medical care in hospitals, one time compensation of Rs 25,000 in case of accident and a grant of Rs 750 for loss of wages @ Rs 50 per day for 15 days. The annual premium for this scheme is Rs 365 for one person; Rs 547.5 for a family of five; and Rs 730 for a family of seven. The BPL families were eligible for a premium subsidy of Rs 100 per annum. The UHIS was revised in 2004 and the scope of coverage is now restricted to BPL families. The subsidy has been increased to Rs 200 against the Rs 365 premium paid for individual coverage; Rs 300 for the Rs 547.5 premium for a family of five and Rs 400 for those paying a premium of Rs 730 for covering a family of seven persons. The scheme however did not take off very well. For one, insurance companies were themselves slow to promote it. Second treatment was not cashless at the point f service, and reimbursement for the individual patient could be time and effort consuming- other than the fact that the poor would not have funds at the time when they need it most. Also the scheme needed voluntary recruitment of beneficiaries and there was no mechanism set up to undertake this. There was also no system of control over providers. Finally the list of exclusions were many and made it unattractive. Most states therefore have preferred to try out their own models. Others have tried to improve upon this model.

Many of the states which have launched state level health insurance programmes include Assam, Andhra Pradesh and Madhya Pradesh. The Assam programme closed down in a year. The Madhya Pradesh scheme for insuring maternity risks also proved to be unsustainable. The Andhra Pradesh scheme continues but requires fairly large government investments and needs to be evaluated.

Meanwhile the central government has launched another initiative in the shape of the Rashtriya Swasthya Bima Yojana (RSBY). This scheme (described in the box at the end) makes many new initiatives and has the potential to expand to cover the entire country. States like Kerala and Rajasthan have significantly

adapted this scheme to bring out their models. Clearly Health Insurance is a rapidly emerging area, which we need to learn more about. The following section describes the general principles of health insurance and how it can be used to assess a health insurance programme.

COMPONENTS OF A HEALTH INSURANCE SCHEME

When planning for health insurance one has to make certain that the pre-requisites given below are in place – or that they would be generated:

1. A community that is in some form organized and can be accessed,
2. Providers of health care must be accessible and must cater to the health needs of the people,
3. There must be an institution/organization with credibility and skills to collect and manage funds.

Also one need to judge

- What is the need for health insurance – are there financial barriers in seeking health care or problems accessing health care services making health insurance necessary.
- Is there a demand for health insurance in terms of both ability and willingness to pay?
- The prevailing cost of care, and morbidity pattern in the community and the ability to pay premium.

The design of an insurance scheme involves the design of many distinct components – all of which are related to each other and to the context in which the scheme is launched and the objectives of the scheme. To a district officer or community or individual who has to choose between different schemes, understanding these principles of design are also useful. Many district officers will find themselves in situations where they are to manage or support an insurance scheme which is already pre-designed at a higher level. For such an officer also understanding these design considerations makes him or her aware of the strengths and limitations of the scheme and this could be compensated for by managing other components of the health sector or raising awareness of the limitations.

The main components of an insurance campaign design are:

a> Benefit package: What are the illnesses covered? What is excluded from coverage? What age groups are covered? Who are excluded from coverage? What is the maximum limit of the coverage- What is the total health expenditure that the insurance package covers (which is also called the sum assured) and what is the amount that can be drawn at one time.

b> Premium: How much – per month, per year is to be collected for each insure. Is it a person or a family getting insured? If it is a family, how is the family defined? What part of the premium is paid by the person getting insured and to whom?

c> Selection and Empanelment of Providers: The cost of care has to be fixed. Also the quality of

care has to be ensured. It should be possible for the insured persons to access these empanelled providers at the time of need.

d> Enrolment of members: This depends on the objectives. It also depends on the scheme design. The insurance company would like the largest numbers to be enrolled for it reduces the risk and one can charge lower premiums. If the government is paying subsidy, it would like to limit the members and choose them carefully- but that may mean potentially more at risk persons get chosen. Is the enrolment voluntary with each one having to pay some token part of the premium or the whole premium or does the government/employer pay for all as part of the scheme. How is the enrolment to be maximised.

e> Authorisation- referral- payment to patient: Ideally when the insured person arrives at the point of service provision he or she should not have to pay anything there- a cashless transaction at this point. But the provider will need to know whether the patient is covered by insurance and whether he or she has used up all the sum assured already or something remains –and if so how much remains. Each scheme has to design this component.

f> Monitoring of programme: There is a tendency of both provider and the consumer to prescribe/ consume more health care than required. There is also a stake in the insurance company rejecting claims. Where the premium has been paid on behalf of the beneficiary the insured may not know about it and may not make the claims. In yet other situations, there may be no provider accessible. In all these situations the claims ratio may be very poor – and this is a poor scheme. For all these reasons and more a good monitoring mechanism needs to be put in place.

g> Third party administrator. Given the complexity of the monitoring and making of claims and payments to hospitals- it may be easier for this administration to be outsourced to a third party administrator. Thus whether the hospital has to provide the service and whether the insurance company has to reimburse the hospital gets decided by the third party administrator. Not all insurance programmes have a TPA. Some consider it a problem, while other schemes require it.

We will examine each of these components below in some more detail.

(a) Benefit package

The benefit packages must primarily be designed to fulfill the programme goals. The benefit package is the return for the premium contribution. Every client would want as much as possible to be included in the package. But one has to be pragmatic so that the premium amounts are reasonable and the scheme is possible to administer. When we examine a package we examine it for inclusions and exclusions. Note that as the benefit package increases, the premium also rises proportionately. Also most health insurance schemes usually exclude some conditions from the cover. For example, many insurers do not cover treatment of HIV-AIDS. Many do not cover cancers or organ transplantations. Similarly, treatment of chronic conditions or very expensive procedures is excluded.

Insurance schemes are best when the benefit packages contain events that are of low probability but high cost e.g. hospitalization. The RSBY scheme is just that. So is Yeshwasini though this is limited to only hospitalisation for surgery.

Though it is possible to cover all outpatient primary and secondary care as well, this is more difficult to manage and all currently planned government schemes are not including it. Out-patient care is also nearly same as the term "ambulatory care". There is one category of care where the patient is bed ridden and cannot go to work but where he or she is not in a hospital setting but rather at home. This is cheaper and more comfortable for the patient. For example a patient who has to take bed rest for a fracture to heal etc. This is called domestic hospitalisation to differentiate it from the ambulatory patient and from out-patient care. Most hospitalisation focussed benefit packages also include some provision for domestic hospitalisation.

Even within outpatient care, community level care is most difficult for insurance schemes to cover. The current trend is for the government to undertake provision of community care and primary health care and use insurance only for financing of secondary and tertiary care- especially in patient care- in both public and private sector. The benefit package is fixed depending on the needs of the community and government to pay for the package and the policy priorities. The benefit package should be affordable to a majority of the population so as to make the product saleable. It is necessary to ensure this, though the government may be paying the premium. Thus the RSBY the poor only pay only Rs 100, but in a state like Kerala the programme has been modified such that even a well to do person can access this scheme by paying the full premium which has been estimated at Rs 750 per year.

The benefit package can vary on the following parameters depending on the specific policy priorities:

- What age group is included: 0 to 60, 5 years to 50 years, 3 months to 50 years? There are all sorts of variations.
- Type of care
    - Is Hospitalization care covered?
    - Is Out –Patient care secondary and tertiary referral care covered?
    - Is primary level outpatient care covered?
    - Is it care at the community level also included?
    - Is - especially diagnostics covered?
    - Is Ambulance cost covered
    - Are there any Pre and post hospitalization expenses provided for?
    - Are any preventive services covered? Counselling for example?
    - Are Routine Medical checkups mandated and covered?

- Are pre-existing diseases covered?
- Are so called "invisible" costs covered
  - Transport costs.
  - Food costs including that of attendant.
  - Loss of livelihood costs.
- What is the sum assured? This varies widely from Rs 2000 in schemes run by small NGOs to about Rs one lakh or more. In the RSBY it has been fixed at Rs 30,000.
- Is the full sum assured available on a single visit – or are there internal ceilings – so much per episode, or so much on bed payments, so much on transport etc.

(b) Premium Fixation

Premium is the amount of money or consideration paid by an insured person or policy holder (or on his or her behalf) to an insurer or third party for coverage under an insurance policy. There are four different rating methods used by health insurers:

- Community Rating – uniform premium from all the individuals in the community as the risk is shared by all the members equally. E.g. Community based Health Insurance Schemes.
- Risk Rating – Premium is based on the risk perceived by the insurer based on medical history, occupation, lifestyle, etc. E.g. Individual Health Insurance Schemes by Private Insurance Companies. Typically older persons have to pay more.
- Income Rating – Premium is based on income/wages. E.g. ESIS
- Experience Rating – Premium based on past loss experience. E.g. Group Insurance Schemes by Private Insurance Companies.

Factors influencing premium include the administrative cost, the marketing cost, the contingency margins, the expected profit margin and the cost of reinsurance.

- Premium = Actuarial value of the benefits + administrative cost + profit/contingency margin.
- Premium = Hospitalization rate x cost per hospitalization episode/Number of members covered + Administrative cost + Profit/Contingency margin.

In a "good" scheme the sum of the payment claims made should be 80% of the total premiums collected, leaving a 20% for payment of salaries and other administration costs for the scheme. This is high – but that is usual in insurance programmes. Profits also are to be limited to being within this 20% range. If the claims ratio falls below 80% either too many claims are being refused, or not enough beneficiaries are aware and making claims, or beneficiaries are unable to access providers or the premium has been fixed too high.

What part of the premium is paid by the individual and what part is paid by the government or employer is a relatively easier matter to decide. But once the beneficiary has to pay part or whole of the premium the manner of collection of the premium which also includes the task of promoting the scheme amongst the people becomes a major component.

(c) Selection and Empanelling of Providers

The benefit package proposed to be offered by any scheme would be the key determinant to decide the types of providers that the scheme should negotiate and contract with. For example, a scheme only covering catastrophic, inpatient care would need to negotiate with hospitals and inpatient facilities only. At the same time, a scheme contemplating provision of primary care would need to engage into dialogue with general practitioners and primary care providers, and perhaps also with diagnostic centres and pharmacies, depending on the scope and the design of the plan.

Usually there are two ways of provision (a) direct provision through employment of providers (2) Purchasing services from private providers. Experience from around the world suggests that employing providers, i.e. direct provision of care by the insurance scheme itself normally leads to quality problems, while empanelling from providers could have implications of cost control. Thus, separation of funding and provision of services is desirable for the health insurance plan. However as we saw in the SAIL example, if the provider of care and the purchaser of insurance overlap, and the provider of insurance is contracted in to do the task, it has less of these hazards. Thus where government public hospitals provide the care and government purchases the insurance on behalf of the poor and the poor also have to pay some premium, but the insurance company is contracted out- there is a better chance of avoiding some of the hazards. The problem of course is of ensuring quality care in public facilities, and the current bias of most insurance programmes to position themselves as only for improved access to private care providers.

The manner in which health care providers are paid can significantly affect both the cost and quality of care, and help in optimal use of resources. Once a patient has taken the step of contacting the provider, it is thereafter the provider who determines, to a large extent, the demand for his or her own services, and the kind and quantity of treatment required. Thus, the provider payment mechanisms determine the quantity of services consumed as well as their costs. They are an important component in the strategic purchasing of health services by insurers, with the other component being that of negotiating and contracting with providers so that they agree to provide health services according to the requirements and conditions of the insurers. Commonly used provider payment mechanisms are the following.

- Fee for service – Payment is done for each service (visit/episode). This can lead to cost escalation by calling for more visits and reducing the time of stay.
- Case Payment – Flat payment on the basis of case. More complicated diagnosis if that qualifies for a higher slab or referral of complicated cases to public providers.

- Capitation – payment in advance for a specified period based on estimations. May lead to referrals away of complicated cases.
- Payment on per-diem basis – Can lead to increase in length of stay of patients.

Most Indian schemes are using the case payment scheme with a flat payment fixed for each diagnosis.

(d) Enrolment of members

The major step in any insurance programme is to enrol members into the scheme. The member enrols herself / himself, either alone or with other members of the family, into the insurance scheme. The various provisions of the insurance scheme are explained to the member during this step and they agree to join the scheme. Individuals are usually enrolled by an agent or a broker of the insurer. In the case of group policies, there will be an intermediary (like an employer / factory / company / NGO), which will undertake this activity of getting the members enrolled under the scheme.

Normally, there will be an Enrolment Form which the members are required to fill in. The insurer or the intermediary will collect various details of the Member (and her/his family) through the process of filling the enrolment form. The profile of the members in terms of their age, sex, previous medical history, pre existing illnesses, address etc. are obtained in the enrolment form. Sometimes, there may be an enrolment fee for joining the scheme, particularly if there is an intermediary between the insurer and the individual members. Each member will be given an identification code (a sort of Membership number) and an identity card with the member details should be issued to the enrolled members.

When the insured member becomes ill, s/he seeks medical treatment from an empanelled provider. In the case of a cashless facility, the insured members are required to go to the provider with the insurance card and the provider would like to assure themselves of the eligibility of the member. However, if the members are required to pay the provider and later get it reimbursed by the insurer, then the members need not present the insurance card to the health care provider.

(e) Pre-authorization / Referral

When a hospital sees a patient, it needs to know not only whether the patient is covered by insurance, but also how much of the sum assured remains in the patient's credit. The latter could present a huge problem as the unit of insure may the family and different family members may have sought treatment at different places at different times. The RSBY propose a smart card that would keep this record electronically and make it available to each provider instantaneously. Most schemes have ways of the

provider contacting the insurance company and getting the information.

Sometimes, the hospitals may have smaller centres or first referral units or health sub-centres which provide a minimum level of health care to the members. In such cases, it will be important to insist on pre-authorization or a system of referral by these centres to the actual provider. This helps to filter unnecessary admissions in the hospital, to encourage reduction of costs for both the patients (like transport etc.) and the provider (lower overheads, picking up cases early enough etc.). Similarly, the hospital may sometime refer the insured patients to a higher level hospital with more qualified doctors and better facilities. In such cases, the referral details are to be intimated to the Insurer / TPA.

(f) Third Party Administrators (TPA)

The basic role of TPA is to function as an intermediary between the insurer (insurance company) and the insured and facilitate cash-less service of insurance. Insurers can now outsource their administrative activities, including settlement of claims, to TPA's, who offer such services at a cost. For this service they are paid a fixed percentage of insurance premiums as compensation, currently fixed at 5.6% of premium amount. The core service of TPA is ensuring cashless hospitalisation to policy holders. Intermediation by TPA's is meant to provide for hassle-free services. Insurance companies pay for efficient and cost-effective services and health care providers get the reimbursement on time. By doing this it is expected that TPAs would develop appropriate systems and management structures aiming at controlling costs developing protocols to minimise unnecessary treatments /investigations, improve the quality of services and ultimately lead to lower insurance premiums.

The following steps are involved from the time of the policyholder informing the TPA to the latter settling the claims.

1. All the records of medical insurance policies of an insurer will be transferred to the TPA once the insurance company has given the business to a TPA.
2. The TPA will issue identity cards to all policyholders, which they have to show to the hospital authorities before availing any hospitalisation services.
3. In case of a claim, policyholder has to inform the TPA on a 24-hour toll-free line provided by the latter.
4. On informing the TPA, policyholder will be directed to a hospital where the TPA has a tied up arrangement. However, the policyholder will have the option to join any other hospital of their choice, but in such case payment shall be on reimbursement basis to the patient who would have to pay out of pocket for the care
5. TPA issues an authorisation letter to the hospital for treatment, and will pay for the treatment.
6. TPA will track the case of the insured at the hospital and at the point of discharge; all the bills

will be sent to TPA.

7. TPA makes the payment to the hospital.
8. TPA sends all the documents necessary for consideration of claims, along with bills to the insurer.
9. Insurer reimburses the TPA

In the RSBY scheme three of the above steps- step 3, step 4 and step 5, which are important and time consuming steps are reduced by the use of a smart card which carries the current information and which can be read on a machine provided to the hospital. Thus the policy holder does not have any contacting to do, provided he or she has arrived at an empanelled hospital with the smart card in their possession.

MONITORING INSURANCE SCHEME

A Monitoring Cell or an Insurance Committee at the District and / or State should be set up level to look at the MIS reports generated by the insurance team on a regular basis. Any regional imbalances, shortfalls in the utilization of health care, high claims ratio, suspected malpractices by some providers etc. can be picked up by this monitoring cell and suitable instructions / suggestions can be passed on to the concerned insurance team.
The most important indicators that need to be analyzed regularly are:

- Percentage of people insured from the target population
- Percentage of insured people who have accessed health care
- Profile of the people who have accessed health care - region wise, village wise, communitywide
- Monthly progress of the claims and reimbursements sent by different providers (if there are more than one), indicating the number of claims and the amounts claimed / reimbursed
- Claims Ratio: The ratio of the amount of reimbursements made to the total premium amount received by the provider
- Status of the insurance fund - a kind of income and expenditure statement, indicating the cumulative premium amount collected under the scheme, reimbursements made, the administrative expenses incurred and the interest income earned
- Liquidity Status: The liquid cash available in the insurance fund at the end of every month (that has not been invested in any instruments / banks). A ratio of this amount to the average claim amount per month will give us the number of months the fund can service the claims
- Report of the rejected claims - reasons for rejection and the claim frequency. An analysis of this report will help the insurer plan an awareness campaign either among the members or among the hospitals about the provisions of the insurance scheme

- Profile of the diseases with which the insured members are getting admitted and the average costs of treatment. Also to interview members to find out what costs they are still paying out of pocket over and above the insurance based care provided.
- If there is more than one provider, then a comparative statement showing the number of members accessing health care, the profile of diseases and the costs of treatment across different providers will be a useful management information report .

It is important that this monitoring be done, not only by the companies concerned but also by the state and district health societies. The regular collection of information on these indicators is critical for the monitoring of all insurance programmes.

CASE STUDY

Rashtriya Swasthya Bima Yojana (RSBY)

The informal sectors in India constitute the major chunk of the total workforce of the country (90%) and are poor, vulnerable and devoid of any concrete social security mechanisms. Despite this fact, a large number of workers engaged in the informal sector in both rural and urban areas are illiterate, poor and vulnerable. They live and work in unhygienic conditions and are susceptible to many infectious and chronic diseases. They receive very low wages; and, as own-account or self-employed workers, they obtain meagre piece-rated earnings. Various studies have shown that the poor and disadvantaged sections, such as Scheduled Castes and Tribes, are forced to spend a higher proportion of their income on health care than the better off. The burden of treatment is particularly unduly large on them when seeking inpatient care. The high incidence of morbidity cuts their household budget both ways, i.e. not only do they have to spend a large amount of money and resources on medical care but are also unable to earn during the period of illness. Very often they have to borrow funds at a very high interest rate to meet both medical expenditure and other household consumption needs. One possible consequence of this could be the pushing of these families into a zone of permanent poverty.

Rashtriya Swasthya Bima Yojana is a health insurance scheme that aims to facilitate launching of health insurance projects in all the districts of the States in a phased manner for unorganised sector workers and their families belonging to BPL category. The benefit package will be designed by respective state governments suiting to their local needs but will ensure a maximum insured amount upto Rs.30, 000/- per family (five members) per annum on a "floater" basis (meaning anyone in the family can access it, with any empanelled provider, at whatever level of expenditure they make till the entire sum assured of Rs 30,000 is used up).. The scheme will cover only inpatient expenses. Exclusions are few and most important; all the pre existing diseases will be covered under the scheme. Cashless hospitalization will be offered to all insured and there will be provision for transportation allowance. The central government

will provide 75% of total premium and state governments will bear the rest 25 %. The administrative costs and other related costs of running the scheme will be borne by the respective state governments and the beneficiary will have to pay Rs.30 for registration and further renewal of the insurance. The total premium cost is estimated at Rs 700.

One important dimension of the scheme is that a smart card given as part of the registration process to the insured family will enable them to access cashless service without reference to the insurer and the provider hospital would immediately know the sum assured remaining in the patient's credit.

Another important dimension is that the public hospitals are also included as providers and in case they access care at the public hospital the insurance payment would be made into the hospital development committee of the public hospital. This potentially provides a mechanism for increase funds to hospitals that are providing more services and part of this could be given as incentives to public employees who are providing these services.

A third dimension of this scheme is that it could be made open to above poverty line persons also if the state so decides, provided they pay the full amount.

Challenges before RSBY:

The current bottlenecks for the scheme are

a. It is difficult to identify and motivate beneficiaries and administratively very difficult to get all the smart cards issued.
b. The number of empanelled providers is few and in many districts the private sector is small and the public sector is not yet geared up.
c. This does not address ambulatory care or community care and therefore represents only a small part of health care needs. But since it is adequate to cover most catastrophic illness, it is a big step forward if it works.
d. In the long run since the private sector is used to changing much higher fees than what the scheme allows them to charge- the scheme would be viable only if the public health sector participates in a major way. And for this improving the quality of public sector service provision and accreditation of this is important.
e. Equally important would be the improved regulation of the private sector so that the entire private sector has to operate within these rates. This is of course much more difficult to obtain.

Review Questions:

1. What do mean by risk pooling in health care? What are the different forms of risk pooling mechanisms existing in India?
2. What do you mean by community health insurance? Briefly examine the various forms of community financing arrangements in India?
3. What are the major components of a health insurance scheme?
4. What do you mean by a TPA and what are their main functions?
5. How would you monitor an insurance programme at the district level?

Application Question:

1. How can insurance schemes be used to fund public hospitals? What are the advantages and disadvantages of such funding?
2. What is the out of pocket expenses on health care in the state and how many persons are completely excluded from all health care? To what extent would insurance help?

Project Work:

- Visit a site where an insurance programme is at work, and try to obtain these monitoring indicators?
- Estimate cost of hospitalisation in private and public sector by interviewing about ten patients. To what extent do you expect the current sum assured cover needs given the ten most common causes of hospitalisation in a public and in a private hospital. Is it viable for the health care provider – public and in private?

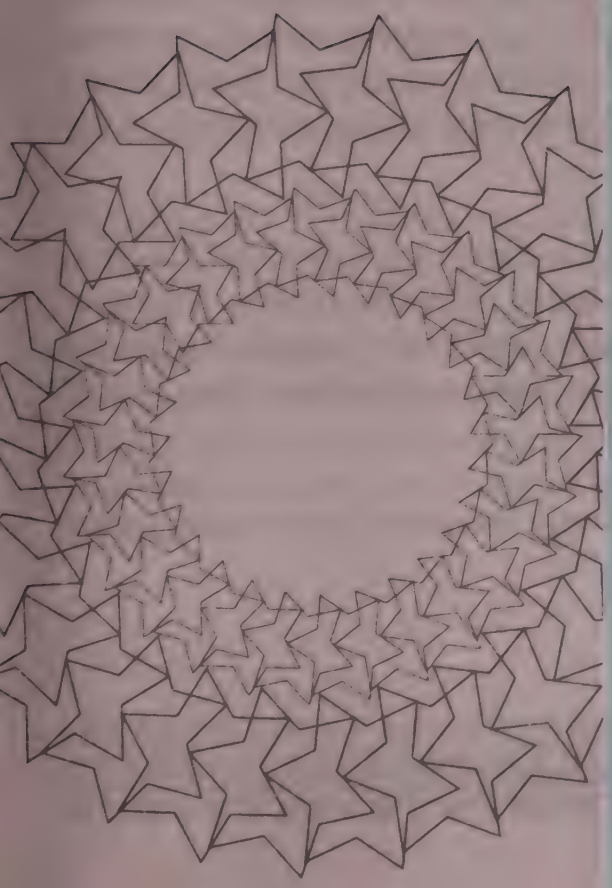
NOTES

Lesson THREE

Engaging the Private Sector: An Overview

In this lesson we shall discuss:

- The role of private sector in health care
- Types of private players in the health sector
- Issues and challenges of engaging the private sector in health care
- Principles of PPP in health sector



INTRODUCTION

At the time of independence the private sector accounted for only 8% of the health care provision in India. Today it accounts for 93% of all hospitals, 64% of all beds, 80 to 85% of all doctors, 80% of outpatients, and 57% of in-patients (World Bank 2001, quoted in Venkataraman et al). Another estimate, used in the Report of the Task Force on Medical Education, (MoHFW, July 2006) describes the private sector as providing 58% of the hospitals, 29% of hospital beds and employing 81% of medical doctors.

In terms of costs the private sector accounts for the majority of health expenditure. According to a World Bank estimate of 2001, India has 87% out of pocket expenditure on health care – one of the highest in the world. At the point of service use it is about 84.6% (Kulkarni et al). In the decade of 1986 to 1996, the number of persons who did not seek health care due to poverty increased from 15 to 24 % in rural areas and from 10 to 21% in the urban areas (Selvaraju and Annigeri 2001).

Public health expenditure in India as a percentage of total health expenditure is just about 22%. This low level of public expenditure on health is amongst the lowest in the world. There are only seven countries lower than this and most of them are war torn Sub Saharan African nations. The corresponding figure for the US is 44%. For the developed industrialized nations of the world excluding the US it is now almost 90%. Total health expenditure in India however is in the range of 6% of the GDP and this is comparable with most countries of the world. Clearly India has one of the largest private sectors in health anywhere in the world.

Within this context of the private sector dominating the scene in the country in the health sector, the district health planning cannot continue planning for health care provision as if the private sector does not exist. Indeed part of the reasons for the slow down or near stagnation of public sector growth in the health care in India, has been the perception that since the private sector and market forces are taking care of the health care provision anyway, and since there is so much dissatisfaction with the public health system- why should the state not retreat from the provision of health care, except in primary health care and that too in a few select cost-effective areas. However such privatization of health services has faced strong opposition largely due to considerable failures especially with respect to meeting the health needs of the poor.

Today the trend of public policy in the health sector is moving towards achieving a public–private mix. Such a public-private mix would be based on a functional public health system, complimented by a number of private players contributing to public health goals through partnership arrangements, where the private sector is also enabled and directed to contribute to public health by the "stewardship" and "regulatory" role of the government.

Before we examine how we can reach such a mix let us understand the nature of the private sector better.

ENGAGING WITH THE PRIVATE SECTOR IN HEALTH CARE

Large sections of the population in India are faced with a dilemma of choosing between the public and the private sector. The public sector though less expensive, is often not easily accessible, unresponsive and lacks accountability, while the private sector, is not available, or if available, it is expensive, often exploitative and equally lacks accountability.

Data and information about the private sector is still limited and there are not enough studies in this area. However we do know that the private health sector is largely unregulated in India. Though the quantum of health services the private sector provides is large but, significantly, often of apparently uneven or poor quality. Of the private sector almost one thirds of the providers are unqualified local practitioners who have just set up practice. Another large sector is Private sector health services have shown a trend towards high cost, high-tech procedures and regimens, unnecessary and often irrational use of diagnostics and therapeutics and are significantly more expensive than public health services. In a series of studies, outpatient services were found to be priced at a 20-54% premium and inpatient services at a 107-740% premium (MoHFW, July 2006).

One important though small segment of the private sector is the not for profit and voluntary sectors. Studies looking at the functioning of non-government organisations (NGOs) show that they have produced dramatic results through provision of primary sector health care services at costs ranging from Rs.21 to Rs.91 per capita per year. Though such pilot projects are not directly scalable, they demonstrate the importance of being able to reach out to and include and even promote some of these care givers as useful and necessary supplements to the public health system.

Given the fact that there is such a large and diverse private sector, and that for so many reasons peoples are using it, there is a need to engage with it, so as to achieve public health goals. Much of the nature of engagement that can be done at the district level requires policy initiatives at state and national levels. However there is a need for district health managers to learn about the general principles of this, so as to have a better understanding of their role vis a vis the private sector in their district.

Engaging with the private sector has two major components- one is of regulation of the private sector and another is a variety of public private partnerships.

In the area of regulation, some states have enacted laws for this purpose. Many more have passed laws but not followed through with issuing the rules or with implementation due to a number of reasons. At the national level, the Clinical Establishments bill is the major effort in the direction of regulation, and when it is passed and rules are framed it would make it mandatory for states to enact and implement laws in this regard.

Public-Private Partnerships have been discussed as one of the options to check the lack of accountability of the private sector and influence the growth of private sector with public goals in mind. Under the Tenth Five Year Plan (2002-2007), initiatives have been taken to define the role of the government, private and voluntary organisations in meeting the growing needs for health care services, including RCH and other national health programmes. The National Health Policy-2002 envisaged the participation of the private sector in primary, secondary and tertiary care and in this context recommended suitable legislation for regulating minimum infrastructure and quality standards in clinical establishments/medical institutions. The policy also advocated the participation of the non-governmental sector in the national disease control programmes in order to ensure that standard treatment protocols are followed. The Ministry of Health and Family Welfare (MoHFW) has also developed guidelines for public-private partnership in various National Health Programmes- notably in blindness control programme and in the tuberculosis control programme. However, States have varied experiences of implementation and of success of these initiatives.

One key issue that is debated in public private partnerships is whether we can expect many private partners to come in and perform in a regulated atmosphere, when most private players are functioning outside the partnership framework in an unregulated manner. The National Rural Health Mission has taken a position that public private partnerships are needed, but as supplements to strengthening the public health system. We need to understand the reasons for this.

Compulsions for Engagement with the private sector:

The government and the public health system need to engage with the private sector. To date it has largely been a passive observer of the growth of the private sector. Of course there are some ways in which the government has always promoted it. Firstly almost all doctors and nursing students practicing today are from highly subsidised or completely government funded educational institutions. Secondly in helps acquire land under public land acquisition bills and gives it free or a minimal costs to private sector, especially the corporate sector to build large and expensive hospitals. But by far the most important contribution is that by failing to fund and expand the public sector in health in tune with the increasing population and needs, it has acted as a indirect promoter of the private health care system; a process that has been referred to as passive privatisation. Poor quality of care subsequent to poor governance has also contributed, but it is the policy of the nineties which saw governments as having a limited role and private sector expansion as a desirable goal which has been the biggest spurt to the growth.

It is now recognised by all sections that a passive growth of the private sector does not help, and may even hinder the achievement of public health goals. The government needs to play a more proactive, stewardship role – in shaping and influencing its growth so as to use its strengths to achieve public health goals, and also play a regulatory role – to ensure that citizens' rights to health care are protected.

The major compulsions for the district health plan to incorporate engagement with the private health sector could be elaborated as follows:

1. **Because it is there** – and it is playing such a big role in curative health care. One needs to shape the growth of the private sector in health care and influence it. Its growth is driven by its commercial interests which in turn depend on its ability to provide cure or relief for diseases. Public health system's focus is on prevention of disease, but it also needs to increase access to quality curative care and in this aspect, the private sector could contribute. The private health sector is heterogeneous and different categories of the private sector can contribute in different ways – with or without formal partnership arrangements.

2. **For Strengthening the Public Health System:** Because it can be used to strengthen the public health system by strategic alliances. Part of it can be made to serve as an extension of public health care provision, an additional service delivery capacity to serve the needs of the poor.

3. **For Protection of the Poor from the high costs of private care:** More than 40% of hospitalized persons have to borrow money or sell assets to cover expenses and up to 35% of hospitalized persons fall below the poverty line because of hospital expenses. As many as 2.2% of the population may be falling below the poverty line because of hospital expenses.

4. **For Access to Some Specialised Services:** In many areas, some categories of care are available only in the private sector and for structural reasons it is difficult to provide them in the public sector. In such areas and for such care, access to the poor requires schemes through which the poor can access care in the private sector at an affordable cost to themselves.

5. **For Reducing Unfair practices and Ensuring Ethical Service:** Because the private sector is largely unregulated and its commercial interests are a major motivating force, it is likely that there is a high level of unfair practices and conflicts of interest situations. The government has a duty to ensure that its citizens get a fair deal; the government thus needs mechanisms of monitoring and regulating the private sector.

TYPES OF PRIVATE PLAYERS IN HEALTH SECTOR

In order to comprehend the possibility of engaging the private players in the health sector, it is useful to categorise them on parameters like profit motive, the degree of organisational complexity, by types of health care services provided, and other support function provided by them. This helps in placing the private players in the health sector vis-à-vis their strengths and weaknesses, thus helping us in engaging them effectively.

Classification of Types of Private Players in the Health Sector

One way of classifying the private players within the health sector, is to look at their organisational complexity vis-à-vis their profit motive[1] (or lack thereof). In this regard, it may be noted that the "non-profit" or "not-for-profit" had been differentiated from the "voluntary" organisations, with the idea that the connotation of "non-profit" applies to organisations not working for profit motive but modelled more-or-less as a body corporate, with formal division of labour and hierarchy. Whereas, the "voluntary" organisation connotes organisations not working for profit and structured informally around a few individuals, working with the community at the grassroots level. Even where the voluntary organisations resemble a formal and professional management structure and hierarchy, the essence of the internal governance and policy is more informal than formal.

Private Players in Health Sector, by type of Organisation & Management

	For-profit healthcare providers	Non-profit healthcare providers	Voluntary healthcare providers
Highly complex organisation	• Corporate hospital chains • Private medical college & hospitals	• Mission hospitals/ Church hospitals operating nationally/ globally (e.g. CMC, Vellore) • Philanthropic institutions • Corporate social responsibility(e.g. Tata Cancer Hospital)	Health services provided by NGOs funded by large funding agencies, (Aga Khan Foundation, CARE
Moderately complex organisation	• Private hospitals, nursing homes, diagnostic centres	• Smaller Missionary / Trust hospitals with or without outreach services	• Outreach/mobile clinic services provided by reputed NGOs
Simple organisation	• Private doctors, clinics • RMPs • *Quacks*	• Private doctors providing services in outreach camps organised by missionary/ trust hospitals/professional bodies */ traditional healers whose main livelihood is different*	• Local NGO providing symptomatic screening & referral services usually by health camps • Health services run by workers and motivated health rights groups who identify with the poor.

[1] One definition of No-profit motive states that 80% of the total fund inflows/earnings of the organization must be spent for the declared organizational goals and purposes within the same financial year, and the "surplus" cannot be paid out to anyone as dividends, but has to be re-invested in the organization. Of course one could stay within this division and still give large salaries to senior executives and board members. An institution that is conscious that it is defined by the purpose of working for the poor, and that therefore the salaries and perks are often called voluntary health care providers. IN practice it is difficult to separate the two.

Highly complex for profit organisations tend to be more professionally managed and have more skills, but are expensive and less motivated to serve the poor. Some of them may however be willing to support not for profit extensions of their main enterprise. The simpler the organisation the more likely their participation if suitable terms to attract them are put in place. Similarly not for profit and voluntary groups would be easier to attract into partnerships.

Another way of classifying the private providers of healthcare might involve looking at the types of services/ healthcare provided by them. These may include the following types:

- Hospitals
- Dispensaries/Diagnostic centres/clinics
- Pharmacy shops/outlets
- Private AYUSH (non allopathic) clinics and providers
- Fitness centres (VLCC, gyms)
- Traditional Birth Attendants (TBA) / Dais

Also, within the domain private sector in healthcare, there are players who are not health care providers in the strictest sense of health "care", but nevertheless play a crucial role in the health sector. Some of the types of such "non-care giving" private players in the health sector may include the following:

- Corporate houses (CSR – Corporate Social Responsibility) – a major source of grants for community level programmes and initiatives.
- Academic and Research Institutions – act as repository of knowledge and evidence of best practices, crucial for training, capacity building and policy advocacy.
- Cooperatives, SHGs – ideal for community mobilisation and community financing initiatives.
- NGOs not providing healthcare services – crucial for community mobilisation and awareness generation.
- Pharmaceutical companies – active in clinical trials and also in sponsoring CME (Continuous Medical Education) and other meetings and conferences
- Media and Advertisement agencies – a crucial partner in mass awareness and mobilisation campaigns.
- High net-worth philanthropic individuals – a crucial source of monetary or in-kind donations.

Engaging in partnerships would have to suit the strengths and capacities of the available private sector partners in the target region and appropriate strategies have to be framed accordingly. Below, we look at some of the strengths and weaknesses of some major categories of private players in the health sector.

Major types of Private Players and their relative Strengths & Weaknesses

Types of Private Players	STRENGTHS	WEAKNESSES
1. Big corporate hospitals & private medical colleges	• Have resources to invest • Well established management (and possibly quality) systems • Good managerial and technical capacity	• May not be interested in serving the poor because of profit maximisation motive: Have to show high returns on investment made by shareholders • Concentrated in big cities, far from the interior pockets/regions • Wield influence at policy level, may not be open to monitoring by district and sub-district level officials
2. Small private hospitals, nursing homes (including diagnostic centres)	• Good technical capacity- but not always. • Generally good rapport with local population. • Available in many block and sub-block towns	• May not have resources to invest • Largely unregulated • Profit motive, may not be interested in serving the poor • Concentrated in urban areas, not very accessible by marginalised population groups
3. Private clinics/ doctors	• Good technical capacity- but not always • Flexible- • Very good rapport with local population • Greater dispersion and available in almost all towns.	• Lack of spare time, more interested in private practice • Unregulated
4. NGOs	• Good reach within the marginalised population segments • Some accounting and monitoring systems in place • Flexible	• Funding dependent, generally not self-sustaining • Generally low managerial capacity. Specific NGOs in health sector may have very high technical capacity. • Localised, difficulty in scaling up

Types of Private Players	STRENGTHS	WEAKNESSES
5. CBOs (SHGs, Mahila Mandals)	• Good rapport within the local community/population segment • Flexible	• Generally low technical and managerial capacity • Localised, difficulty in scaling up
6. Academic & Research institutions	• Broader strategic/policy level perspective • Good resource base for monitoring & evaluation tools and systems • Capacity for trainings	• Generally lack community level rapport for effective field level implementation. • May have little experience of operational and implementation issues.

When considering bringing in private players we need to know not only the relative strengths and weaknesses of the major types of private players and their presence (or absence) in a given state/ region, but also the state of the public sector there and what is being done to strengthen it.

PUBLIC PRIVATE PARTNERSHIP (PPP) IN HEALTH SECTOR IN INDIA

Public Private Partnership or PPP in the context of the health sector is an instrument for improving the health of the population (Report of Task Force on PPP for 11th Plan, MoHFW, 2006). PPP is to be seen in the context of viewing the whole health sector as a national asset with health promotion as goal of all health providers, private or public. The Private and Non-profit sectors are also very much accountable to overall health systems and services of the country. Therefore, synergies where all the stakeholders feel they are part of the system and do everything possible to strengthen national policies and programmes needs to be emphasized with a proactive role from the Government.

For definitional purposes, "Public" would define Government or organizations functioning under government budgets. This would include institutions run by central and state government and by local governments. "Private" would include both the commercial or Profit and the not for profit and Voluntary sectors. "Partnership" would mean a collaborative effort and reciprocal relationship between two parties with clear terms and conditions to achieve mutually understood and agreed upon objectives following certain mechanisms.

The Public Private Partnership (PPP) is considered an "essential strategy to extend the scope of the existing health system in the nation-wide perspective and securing the willing cooperation of private

sector, NGOs and social activists for this purpose" (Workshop report, National Planning Workshop on PPP in Health sector in India, Department of Planning & Evaluation, NIHFW, 2005). This does not however mean that the government would reduce or forfeit its key responsibilities.

During the nineties and early part of this decade there was a large and sometimes dominant body of opinion that public health systems were inherently inefficient and would never be able to delivery quality health care. Also that the government could not afford to provide health care for all- and should therefore limit itself to providing a small cost-effective package of health services, leaving the rest of the health care provision to the private sector. This was often backed by a great deal of criticism of public health services with several studies highlighting their inadequacies. The main reason for PPP in this stream of thinking was to change the government's role from being a provider of services to being a purchaser of services for the poor.

Today the lowering of the share of public responsibility in health and the dilution of the government's role as provider is seen as a mistake with major adverse consequences. This is particularly evident when one examines the increasing gap in mortality indicators across social groups, the resurgence and outbreak of epidemics and the poor and unequal access to basic needs for large sections of the population. The gap in mortality indicators between different social groups, viz. scheduled tribe, scheduled caste and others reflects the extent of deprivation that exists among the vulnerable sections and the relative prosperity of the middle and upper middle classes.

Today we understand the poor performance of the public health system to be largely due to the tremendous lack of investment in the public health system and the failure in planning the human resource component leading to an understaffing of most facilities, Poor management have all contributed to the decline of the public health system. Despite all these problems, for the poor, the public health system continues to remain the important source of care and what also keeps the private sector within some limits n cost and quality.

It is in this context, the importance and the need of a partnership in the health sector becomes important. While partnerships are made to ensure that the huge private sector also contributes to public health goals, there is emphasis given to the need to leverage p partnerships to use investments and human resources and skills available with the private sector to revitalise public health systems and to achieve public health goals.

Middle and upper sections of society see the government's role in putting insurance mechanisms and regulatory mechanisms in place as a way of increasing their access to quality care in the private sector. Though this is applicable to the poor also, the State still remains "central to individual and collective life" and hence the poor perceive a greater role for the state in providing health care. Hence, both increased access to private sector without adverse economic consequences and strengthening the public health provider role both proceed in parallel. Both need major and increasing levels of government involvement and both need partnerships with the private sector

The private sector has come in for criticism because of high cost of treatment, its reluctance to reach rural areas because of the risks involved and therefore only catering to selective section of the population. However, the private sector also brings with it much needed bed capacity, and skilled human resources and some degree of efficiency. And there is no escaping the need to build viable and pro-poor partnerships with it.

PRINCIPLES OF PPP IN HEALTH SECTOR

For a relationship between government and private sector to be called a PPP, it must be based on common objectives, shared risks, shared investments and participatory decision-making.

Some of the principles, which may underlie the broad framework of partnership arrangements within the health sector, may include the following:

(i) Pro-poor, Objective oriented planning involving all concerned stakeholders – this implies making clear what the PPP is intended to achieve, and how it would serve the poor. The benefits to the poor may be immediate and tangible or may be long term and indirect. However for public investment to proceed it should be demonstrably promoting equity and it should involve the stakeholders at the design stage, considering the fact that Health care is not a typical consumer products but rather a universal human right, which means any partnership would have to give adequate attention to equity and accessibility by marginal population groups, apart from financial sustainability issues. The Memorandum of understanding must clearly state the objectives and the measures which allow access to the poor.

(ii) Joint Decision Making Process – this is to strengthen the true value of "partnership" where the partners (public and private) act jointly and take major decisions (on design, protocols, extension, grievances, etc.) jointly. Institutional mechanisms for this should be built in and written into the Memorandum of Understanding.

(iii) Output Based Funding – this is to ensure the financing of PPPs are directed towards measurable outputs, making the partners focus on deliverables rather than the inputs. It also gives the partners flexibility in adjusting inputs to deliver the desired outputs. These too should be written into the memorandum of understanding.

(iv) Accountability and Responsibility for partners – all the partners in a partnership initiative (public and private) must have defined responsibilities and there should be systems in place for making all the partners accountable for their pre-defined responsibilities. A transparent regulatory mechanism is an integral part of such an arrangement. All these should be a part of the memorandum of understanding.

(v) Sharing of costs and resources – this principle is basically based on idea of shared risks and rewards for all the partners in a partnership arrangement. The Memorandum of understanding should be explicit on this aspect also.

Though all 5 principles elucidated above are essential in a PPP, we will find few or almost no examples that would qualify if we apply these. For example decision making is seldom if ever joint, the government having decided the scheme first. In many relationships loosely called PPPs the private partners brings in no investment. Even where they share in the investment, there is not any example of their sharing in the risks. Nevertheless every single relationship should be tested against these five principles to see how far they go. A simple exercise is to take the MOUs of existing PPPs and test it against these five principles.

Another set of principles relate to ensuring that PPPs are pro-equity and not concealed forms of privatization. These were best stated in the alternative people's health plan and are quoted below:

a. That the mechanisms of access to the poor are clearly defined and there are mechanisms of enforcing its adherence. These could be through social security/insurance options or other demand side financing options or it could be through reimbursement to the hospitals for their management of the poor.

b. Quality and Cost Regulation of service delivery and a transparent system of monitoring would have to be in place and these should be structured such that it can be expanded into a system where all private and public health facilities are eventually so monitored. The systems of contracting have to be friendly to such monitoring and have the ability to prevent inappropriate care and costs.

c. That PPPs should supplement and strengthen public sector but not substitute or weaken existing public health care services, (for example: a center acting as referral center for emergency obstetric care in an area where government is unable to recruit and deploy gynecologists adds to the effectiveness of the rest of the services being provided in the public health system, or an ambulance services run under PPP can bring more sick patients in time to the public health facility, or a contracted out diagnostic service improves the quality of care in the public health system).

d. Expanding/bringing in investment working for the public health goals: Which would mean no transfer of assets and resources from public ownership into private hands. This should be acceptable, as the efficiency of private sector is critically dependent on it having to invest its own capital in it. (This would largely exclude contracting out CHCs and PHCs to private parties. The management contract of the "Managed Care" approach is a variation of this and is discussed separately in the box 1).

e. Prompt payment with dignity for the private sector partners so that ethical low budget proprietary services in smaller towns are favoured.

f. Ensuring that efficiency is based on better management practices and not based on unfair wage structures and compromised social security benefits, especially for women health care providers like ANMs and nurses.

g. Clearly demarcate the commercial private commercial sector from the not-for profit and voluntary sector in health care provision and treat them differentially.

h. Exclusion of private nursing homes where government servants are providing services from such a framework – to avoid a conflict of interests.

Again when designing a PPP or any form of engagement with a private service provider, or assessing an existing arrangement, it is useful to measure this arrangement against these principles. These principles may not find explicit mention in the MOU, but nevertheless are important framework principles to decide about the desirability of a particular form of engagement with the private sector. Again we may find that many forms of engagement do not qualify on one or more principles. That would help us understand and take corrective action where required.

KEY ENABLING FACTORS for PPPs

The Government has to play an active role in many areas if PPPs which are consistent with public health goals has to emerge.

(i) Setting of Standards- Quality and Costs:

As is evident from the existing PPP models in India, partnership mechanisms do not work without quality assurance and an enabling environment. So, the Government has to ensure that

- Standards are set and followed
- Guidelines and protocols for diagnosis and treatment are developed and used
- Costing of services is based on empirical evidence, which is provided and updated by the state through a suitable mechanism
- Providers are kept updated through continuing medical education, and that
- Providers are accredited

(ii) Setting up of Legal Framework Systems:

Setting of standards would have to be supplemented by establishment of a legal framework that would include:

- Establishment of a regulatory mechanism to ensure the maintenance of adequate standards by diagnostic centres/medical institutions, as well as the proper conduct of clinical practice and delivery of medical services. In this way, monitoring of such important aspects of quality as infection prevention, client satisfaction and access to services can be assured for the private sector also. Such a regulatory mechanism is also mandated by the clinical establishments bill and the proposed national health bills. These have not yet been passed by parliament. In the absence of such a regulatory mechanism effective PPPs may remain limited to some well motivated not for profit partners.
- Specific legislation to support PPP: This is a pre-requisite to sustainable and widening of PPP, involving higher investments by the private partners and ensures regulation by the government. This may be needed for some areas where PPPs are essential- for example in the management of emergency care, or special skills which are available only in a few private sector units.

(iii) Setting up of Management Systems:

- The establishment of a comprehensive information system.
- The establishment of systems for decentralised decision making and financing: Decentralisation may be the key in dealing with partnerships as it facilitates development of pragmatic and better workable solutions.
- Establishing systems of enhancing managerial capacity to make the process accountable, affordable and accessible to the public. This in turn needs building up of technical assistance capacity to support establishment of PPPs.

DESIGN AND OPERATIONAL CHALLENGES:

Some of the key challenges in operationalising effective PPP in health care provisioning are as follows:

- Feasibility study may be undertaken through professional bodies before embarking on any PPP initiative. Costs and economic considerations need to be considered while designing any PPP model. Operational cost per unit service at different levels of public health facilities may be worked out to decide price per unit of service which could be used for reimbursement by the government or to regulate user fees charged. And the concept of cost should go with the concept of quality.

The challenge would then become building a system which is efficient enough to monitor both the cost and quality of service provision.

- Efforts need to be made to design partnership arrangements for long-term sustainability. The memorandum of understanding or agreement is the most important expression of this design. Working guidelines for drafting MOUs to build structured partnerships, based on successful experiences of States, MOU/contract agreements, control mechanisms, monitoring and evaluation, feedback on systems and procedures etc. which have proved successful should be documented and disseminated among stakeholders to be replicated in un-served areas.

- Designing monitoring systems which are efficient and which can be trusted is a challenge. In the absence of a regulatory framework, where all service providers are forced to play by a basic set of rules, the possibility of being able to have an engagement with only a few motivated health care providers is difficult – for each private health care provider has also to survive in a very competitive and demanding environment.

- It is important to understand community dynamics in implementing any health programme. Therefore, ownership by the community would prove a clinching factor for sustainability of any PPP arrangement. *Panchayati Raj* Institutions (PRI) and Community Based Organisations (CBO) should be involved in monitoring and evaluation of PPP initiatives to build credibility and trust. Some forms of social audit should also be put in place. Appropriate scheme(s) could be designed to rope in co-operative societies and NGOs to improve health services coverage through PPP. This section should be treated preferentially as compared to *commercial players*.

- Public Private Partnership needs to be mutually beneficial to both parties *so that there is* encouragement of entrepreneurship and innovation. It is important that health professionals in PPP ventures also make sufficient financial gains to sustain the partnership. However, the earnings should be commensurate to the health services provided, especially *to the poor*. This could be enabled through the volumes *of patients which* the private sector *would be getting from* the public sector partnership. But it also needs tight monitoring. The commercial instinct is to do the opposite – lesser volume of work and more returns. By ensuring a different framework, one creates a context where more pro-poor providers, or newly starting up clinics, or NGOs find a favourable environment and begin providing a large share of the private sector provided services. This influences the character of private sector growth.

Another area of concern is ensuring that payments are made to the private providers promptly and with dignity. This ensures that smaller more ethical players survive- who would otherwise be the first to be squeezed out, and it also ensures sustainability of the partnership with all players. The tendency is to trust the large corporate houses and to be very suspicious of small players. However the mechanisms of monitoring should look at all service providers with equal rigor and ensure that in the name of monitoring the small players are not subject to unfair pressures.

Corruption is ubiquitous, both in public and private sector. Absence of regulating principle makes it more difficult to handle. Some sorts of transactions lend themselves to greater corruption than others. Where there is no transfer of public funds or public assets as investment into private hands the scope for corruption is much less. Payment for services rendered is much less subject to these risks, if there is an adequate monitoring system in place. Most scams in the name of PPP involve transfer of crores of funds or land into private hands for services that would be provided at some future date. Such schemes always require closer scrutiny. Designing PPPs in an atmosphere where governance mechanisms are still weak is a major problem.

Public private partnerships should expand investment in health care and increase number of service providers. Also the efficiency of the private sector depends a lot on it sharing in investment and risks. Where it does not have a share in this, the private sector could be even more efficient. Also care needs to be taken that the PPP is not substituting public services with private sector services. PPPs should supplement existing services- adding service providers or adding new services and increasing the overall number of patients being seen. Designing PPPs such that partners bring in their own investment and are not waiting for government assets or funds to be transferred to them is a challenge.

Review Questions:

1. What is the extent of health care expenditure that is out of pocket expenditure as compared to public health expenditure? What does this mean for the relationship between poverty and health?
2. What are the main compulsions of engaging with the private sector?
3. What principles should govern the design, implementation and monitoring of partnership arrangements in the health sector?
4. What are the types of for-profit health care providers?
5. What are the key enabling factors for PPPs to be pro-poor and effective?

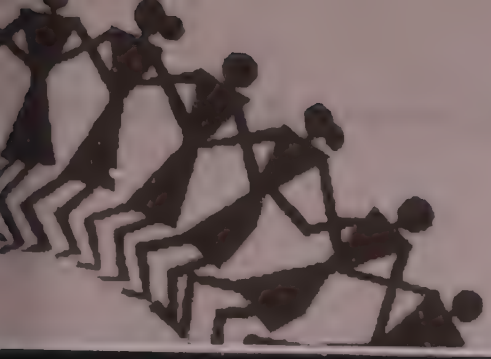
Application Question:

1. What is the general public's perception of the private sector operating in the district as compared to their perception of the public health system? One needs to make this inquiry at different socio-economic levels.
2. Are there NGOs (especially MNGO/ FNGO) in the district working on health projects? If yes, how are they supported and monitored?

Project Work:

- Enumerate the different private players active in the health sector and their relative strengths and weaknesses, in one block/district as a team effort. Develop a broad strategy of involving them for strengthening the public health system and achieving the broader public health goals.
- Examine the MOUs of a few PPPs in your district/state. How well does in conform to the principles described above? If it does not conform, how could the design be altered and reflected such that it conforms?

NOTES

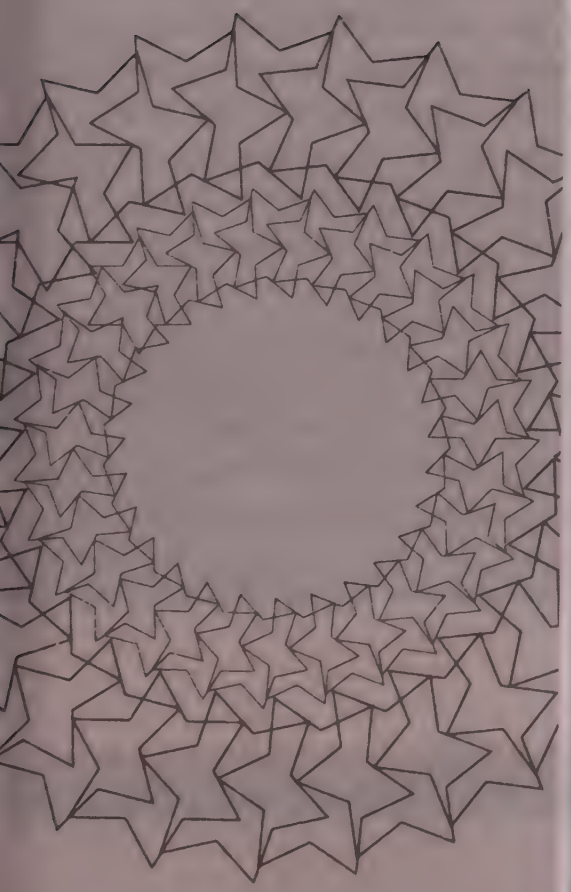


Lesson FOUR

Health Care Financing : Overview

In this lesson we shall discuss:

- Demand side financing in health.
- Voucher Schemes.
- Chiranjeevi Yojana.
- PPPs for JSY



Demand side financing in health

In India healthcare is financed through general taxation and provided through the government healthcare system. It is not easy or useful to categorize all health care activity in the country into public or private. A much more useful categorization of the health sector rests on a four fold categorization based on ownership of the facility and on the source of funding of the costs of health care provision. These are the following:

Public Provisioning- Public Funding: This would refer to the government run free health care services. In practice there are many charges that the user has to undertake- so it is never fully free. However the majority of the expenses are paid for by the state and typically cost recovery is less than 10%. Some of these could be public private partnerships if the management of these institutions is contracted out to a private party. Typically now a number of NGOs are taking up CHCs and PHCs on management contracts. Though one could therefore call them private provisioning, since the investment – both capital costs and recurrent costs- is still almost entirely by the government these are best discussed also as public provisioning and public funding but with partnership as private management contracts.

Public Provisioning- Private Funding: This would refer to the government run health care services – but where most of the costs are fully recovered by user fees and charges. In practice there are very few government facilities that recover costs- especially capital costs -as their aim is in providing health care to the poor. However if social insurance is linked to the system and payments are made by the insurance firm then this form of health care provision would become more common. Of course the premium of the insurance company would have to be paid at least in part by the government.

Private Provisioning- Public Funding: Many public private partnerships belong to this group. The health care provider is a privately owned establishment but instead of the user paying out of his own pocket, the bills are paid by the government. There could be many types of such payment with either the provider or the user receiving the payment. There are other types of contract that fall in-between these two types. The Chiranjeevi scheme of Gujarat is a typical example of the provider reimbursement arrangement. The PPPs wherein private providers are accredited for Janini Suraksha Yojana and users getting institutional delivery care from them are reimbursed is a typical example of an user reimbursement arrangement. Of course the latter is only part reimbursement. In mediclaim scheme there is full reimbursement. CGHS, ESI also provides full user-reimbursement when the cases are referred to private providers by the government facility.

Private Provisioning- Private Funding: This is the typical private care setting. The government has currently no role in this – though it is expected to act as a regulator. There are some important non governmental initiatives that fall within this group as by definition almost all non governmental non commercial providers would also fall within this category. The government has an important role to play – a regulatory role.

Demand Side Financing in Health

In this section we are looking at demand side financing options and how they are different from supply side interventions. In supply side financing, a provider is funded directly, who then in turn is expected to provide services to the poor and ensure that poor have access to free or subsidized services (public facilities are financed according to inputs-normative, numbers of staff, spending on consumables etc).This is a common form of health care financing seen in developing nations. In supply side financing the money precedes the delivery of services.

In demand side financing, the resources follow the use of services by beneficiaries. The role of the government is to identify the beneficiaries and arrange a system through which beneficiaries can access quality services and utilize services properly. The limitation of supply side subsidies is that the target group does not receive them directly. Instead they receive them from service providers. As a result, in the absence of an effective exemption system, the poor who cannot pay may remain excluded or still be failing to get preferential access to free or subsidized services. Also in supply side financing the provider is decided and fixed.

Demand side financing places purchasing power into the hands of consumers to spend on specific services and also to choose between a number of accredited providers. The basic idea behind demand side financing in health is that subsidizing demand among poor for specific health services of known cost-effectiveness, while allowing a competitive market for its provision, may be more beneficial than using the same resources to subsidize supply. This approach enables governments to purchase outputs rather than inputs and offer choice of providers to beneficiaries. Based on these, a generic definition of demand side financing would be a means of transferring purchasing power to specified groups for the purchase of defined goods or services. Following are the advantages and disadvantages of the demand side financing.

ADVANTAGES	DISADVANTAGES
• Potential to target subsidies and reach the poor or those needing it most. Equity can be ensured. • Payment linked with performance • Potentially allows for provider competition and therefore quality • Potentially offers greater choices to users-therefore consumer empowerment and therefore better quality and responsiveness.	• Have significant administrative costs • Complex to set up for larger package of services. For a single service like cataract surgery or institutional delivery it is easier • May have a negative impact on the public sector especially where it is covering a limited range of high value services

ADVANTAGES	DISADVANTAGES
• Encourages efficiency. • Promote public private partnerships where investments are made by the private partners, and payment is only for services delivered. • Use surplus unutilized capacity in private sector.	• Difficulties in targeting, especially if BPL. card is used. • Leakages /abuse • Poor may not take full advantage of this • Provider may avoid selecting the neediest and pick cases which have less risks or more returns.

Demand side options are currently all private provisioning and public funding options. Here the provider is private. Poor are encouraged to access this and the costs of care are then reimbursed. If at the point of transaction the patient does not have to pay anything- no user fees- and then it is called a **cashless arrangement**. If the reimbursement is to the provider – it is called a **provider reimbursement** arrangement. Usually provider reimbursements go along with cashless options. For purposes of monitoring such PPPs always insist on the entire transaction being cashless for the patient with no hidden costs. If the reimbursement is to the beneficiary or patient – it is called the **beneficiary reimbursement** arrangement. But these cannot then be cashless arrangements. Patient would have to pay the provider and claim reimbursement later. Providers are reimbursed by presenting the data on treatment they have provided along with supporting documents. Or they can present vouchers which are given to them by patients when they seek treatment. These vouchers are issued to potential clients/patients – and when they go to seek care instead of cash they can give these vouchers. Each voucher provides for a certain value of care or certain package of care.

Voucher scheme

The aim of most voucher schemes is to attract more private investment in the social sectors in a situation where it is known that the cost of service delivery cannot be recovered by user fees. Voucher schemes are meant to allow a greater choice to the clients and therefore ensure that market forces would act and regulate quality of care. Thus the provider would be more accountable or else lose his clientele to others who are. (It has also been used where a small dispersed category of patients need to access a specialized service that only a few providers provide – like its use for counseling to victims of gender violence).

A voucher is essentially a token of exchange, similar to money but exchangeable for a more restricted range of goods and/or services, either partially or in total. Vouchers are tied cash as opposed to liquid cash. The 'ties' can be in relation to what goods the voucher can be exchanged for, but also in relation to where the goods can be obtained. (i.e. the range of providers may be limited) and when they can be

obtained.(if the voucher has a limited validity).A distinction is made between voucher schemes in which there is competition between service providers, and those in which the voucher is redeemable at a single service provider. Competition substantially increases the potential of voucher schemes to produce efficiency and quality improvements in health care delivered to poor people. Vouchers can be issued for specific target groups. For example, in urban slums for specific services, for sick new born care or for institutional delivery etc.

In voucher schemes, the process begins with the transfer of funds to a voucher agency. Vouchers are then produced by a voucher agency and distributed to a target population, either by the agency itself or to third party organizations who in turn distribute them to sections of the target population with which they have particularly close links. The voucher is taken by the recipient to a health service provider of his or her choice and exchanged for goods or services (or used as part payment for them). Health service providers can be clinics, informal practitioners, hospitals, laboratories or other diagnostic services, pharmacies, community care service providers, health promoters, ambulances or other transport service providers, vendors of prostheses and so on. The service providers return the vouchers to the voucher agency along with any other information that it might require, which then pays the providers a sum agreed in advance for each of the vouchers returned. The voucher agency reports the programme outputs and outcomes back to the government or donor providing the subsidies.

The strengths of the voucher scheme is that is an ideal demand side arrangement which in theory allows users to make their choice and providers to compete between themselves , while at the same time building a mechanism for the poor to be provided cash less service from the private sector. In practice there are few large scale working models and certainly none in India. There are two or three urban child health programmes in the area of Haridwar, Agra and Kanpur that are being piloted- and it is far too early to tell.

The main problems are that it has high administrative costs and the process of recruiting and retaining private providers is difficult. At best it can be used for a very narrow range of well defined services.

Insurance as demand side financing:

It needs to be noted that all insurance schemes are also mechanisms of demand side financing.Schemes like medi-claim which are run by the four public sector insurance companies are user –reimbursement schemes, though they are also entering provider reimbursement programmes. The RSBY in contrast is a provider reimbursement scheme.

Community based insurance schemes could be either user reimbursement or provider reimbursement systems.

Case Study: The Chiranjeevi Scheme in Gujarat

Chiranjeevi Yojna is a demand side financing scheme with private provisioning and public funding arrangement aimed at targeting BPL population. Chiranjeevi Yojna was initiated as a scheme to increase institutional deliveries and to encourage private practitioners to provide maternity services in remote areas. The scheme was launched as a one year pilot project in December 2005 in five backward districts viz., Banaskantha, Dahod, Kutch, Panchmahals, and Sabarkantha and covered all BPL families. The scheme has now been extended to the entire state. When the scheme was initiated the pilot districts were selected based on remoteness and included regions facing highest infant mortality and maternal mortality.

Under the Chiranjeevi Yojana, BPL mothers receive cash-less institutional care at delivery. The beneficiary has an advantage of referring to any empanelled private nursing home or private hospital; get the delivery done (normal, caesarean, or having other complications) without paying the charges. Only those who have BPL cards issued by the village sarpanch are eligible to avail of free services for childbirth in the participating private institutions. These women must also have received antenatal care from a government facility. The benefits package also includes free medicines after delivery and transport reimbursement to the family and provides a monetary incentive to the attendant to compensate loss of days' wages. The scheme recruits private nursing homes to provide institutional delivery and emergency obstetric care services. The private empanelled providers under the scheme are reimbursed on capitation payment basis according to which they are reimbursed at a fixed rate for each delivery carried out by them. The financial package of the scheme was prepared in consultation with SEWA rural initiative and the Federation of Obstetric and Gynecologists Society of India (FOGSI) members. This information was used to arrive at a uniform package rate for 100 deliveries that could be paid to private provider conducting any type of delivery (normal as well as complicated cases), based on the fact that the total number of complications would normally be about 15% and 7% would require surgery. The details of costing of the scheme is given below.

Table: 1 Financial Package for Chiranjeevi Scheme

Procedure	Cases per 100 deliveries	Cost (Rs.) Per Procedure	Total (Rs.)
Normal Delivery	85	800	68000
Complicated Cases			
Eclampsia/Forceps/ Vacuum/ Breech	3	1000	3000
Septicemia	2	3000	6000
Blood Transfusion	3	1000	3000
Caesarean	7	5000	35000
Pre delivery visit	100	100	10000

Procedure	Cases per 100 deliveries	Cost (Rs.) Per Procedure	Total (Rs.)
Other Costs			
Investigation	100	50	5000
Sonography	30	150	4500
NICU Support	10	1000	10000
Food	100	100	10000
Dai	100	50	5000
Transport	100	200	20000
Total	100		179500

In implementing the Chiranjeevi Yojana, the role of district health official has shifted from service provision to that of a facilitator and organizer of services. District health officials in the scheme are involved in planning and selection of private providers in their districts. Management of Chiranjeevi Yojana lies in the hands of the public sector with district health authorities being the coordinating and monitoring authority.

Table 2 District health authorities in the implementation of the Chiranjeevi scheme.

Level	Person responsible	Activities
	District Development Officer (DDO) as Chairperson of Executive Committee, District RCH Society	Overall implementation of the scheme in the district
District Level	Chief District Health Officer (CDHO)	Identification and enrolment of the gynecologist, Orientation about the scheme and Coordination
	RCH Officer (RCHO) and District Project Coordinator (DPC)	Payment to the Chiranjeevi doctors Documentation Technical aspects of the scheme (RCHO) Management aspects of the scheme (DPC)

Level	Person responsible	Activities
	District Project Management Unit (DPMU)	Compilation of information
	District IEC Officer (DIECO)	IEC activity related to the scheme in the district District Level
	District Public Health Nurse (PHN)	Monitor the technical part of the scheme
Block Level	Block Health Officer	Handling billing and reporting Forward bills to the District RCH Society, and Overall supervision of the scheme in the block.
	Block IEC Officer	IEC activities related to the scheme in the block
	Medical Officer (PHC)	Overall supervision of the scheme in the PHC area
PHC Level	FHW, ANM and AWW	Identification of ANC cases to be registered under the scheme as beneficiaries, Explanation of the scheme to BPL, Preparation of birth micro plan, Selection of nearest provider for the identified case, Accompany the mother to the doctors for delivery (if possible), Follow up of the case after the delivery

The total direct cost of the pilot scheme was Rs. 110 million for one year for 5 pilot districts and after extension of the scheme to the whole state, the first year cost is estimated to be around Rs. 506 million.

The initial assessment of reveals that scheme has succeeded in increasing the availability of human resources and been able to provide skilled birth attendance to poor women. The review conducted by IIM Ahmadabad found that most of the Chiranjeevi users have income levels less than Rs. 12,000 per annum indicating the scheme is able to target the poor families in the study area. The average expenditure

incurred by the Chiranjeevi beneficiary on their previous delivery was Rs. 3070. The expenditure incurred by non-user group on recent delivery at a private facility is Rs. 4000. In contrast a Chiranjeevi client has spent out-of-pocket on an average Rs. 727 per delivery on medicine (self Rs. 297, child Rs. 358) and transportation Rs. 72. Though this indicates that the delivery is not really cash-les, the average amount saved by the Chiranjeevi client by availing the benefit of the scheme is Rs 3273 (Rs. 4000 minus Rs. 727).

However there are some issues related to implementation of Chiranjeevi scheme.

Target population: The identification of a BPL individual is done based on the BPL card issued by the district revenue authorities. Targeting here is dependent upon the manner in which the BPL cards are issued and many needy families get left out. Others on the margin get no benefit altogether.

Not entirely Cash Free: The beneficiaries still pay for themselves and their child's medicines. Thus, the transaction is not entirely cash free. However, whether medicines prescribed are actually required or not is to be seen. Also there is no reason for the doctor not to have given the medicines himself, and this may be really a result of poor monitoring and contract management. Moreover, reimbursement of transportation expenses are also often incurred by the beneficiaries partially as the assigned amount does not cover it up entirely. Transportation costs for one accompanying member should also be provided. In many cases, many people accompany the mother increasing the costs. In addition, there is no facility for providing care to the new born or post natal care or ante natal care within the scheme. This implies that once the delivery has taken place, the empanelled doctor is not responsible for the survival of the new born. Even in pregnancy only a very narrow period is covered.

Transportation: Availability of modes of transportation is very important in the hinterland. A rapid assessment done by UNFPA found that the time taken to hire a vehicle was as much as time taken to reach at a place.

Framework: In normal circumstances, the FHW through AWW, TBA and word of mouth communication comes to know that the woman referred to the institution has come back. She then provides not only post-partum care but also initiates child immunization services. However, there is no proper linkage between private institution and public health system for follow-up after the beneficiary is back from the hospital. This is an area that has to be strengthened. Thus, post delivery institution linkages need to be developed. Moreover, the field level worker is not informed if a provider drops out. Not only does this make the mechanism lack credibility, it also causes undue complications to the beneficiary.

Pricing: On the pricing aspect, by making a normalized package for normal and complicated deliveries, a trend to refer away complicated cases- skimming- has developed. Many doctors refer the clients under the pretext of unavailability of anesthetist, ICU, blood etc. If differential payment for normal and complicated cases is introduced there is the risk of unnecessary surgeries. The pricing has to be updated regularly through a rigorous and transparent methodology.

Providers' qualification: The providers should have adequate facilities to be empanelled. Most of the

providers are not adequately equipped to carry a C section such as a pediatrician, anesthetist, blood bank. Moreover, under the pressure to perform program managers tend to empanel the providers who are willing, ignoring whether they are fit for the purpose or not. This must be stopped in order to make the scheme fully effective. Moreover, such a method gives the providers' an excuse to refer complicated cases to district hospitals. These providers should also be made fully aware of the details of the scheme and guidelines on standard definitions of obstetric care need to be laid down.

Payments: Payments to the providers need to prompt. Since there has been a change in modalities of payment from advance payment to reimbursement to private providers in the course of scheme implementation, timely payments need to be stressed all the more for building and maintaining the faith of the providers in the system.

Renewal: Renewal of contracts also needs to be prompt in order for the scheme to be fully effective

Quality Monitoring Mechanism: It has to be ensured that ample amount of hospitalization time is provided for different types of deliveries. Since the district officer is responsible for the doctor's reimbursement and not the patient himself, the doctor can be negligent in provide quality services to the patient. Thus, there should be a quality monitoring mechanism that ensures that the doctor is not encouraged to deliver babies but to provide adequate health care to the mother and the child. Special provisions to the patients for addressing complaints can help in this to an extent.

Strengths of the scheme:
Provides cashless service to the BPL- though service limited to institutional delivery and emergency obstetric care at delivery.
Provides emergency obstetric services in areas where there was none.
No investment transferred to private hands.
Prompt payment of providers with dignity.
Only of two public private partnerships in RCH area that has been rated as suitable for replication, and which fulfils most of the principles of a PPP.

Weaknesses- especially for replication.
Needs stronger independent monitoring system in place. Charges of not providing treatment in a cashless way with some double-charging would increase if monitoring is weak. Tight monitoring would reduce number of partners but would provide preference for non commercial players.
For it to be a supplement and not substitute to public sector- the private providers should be available and distributed where public service providers are not present. This condition appears to be satisfied in Gujarat with a much higher number of specialist gynecologists in private practice in block towns. Such numbers and dispersal is not available in most other states and therefore as of now replication as neither been easy nor as successful.
Narrow spectrum of clinical care is being provided. Though this could be considered positively as a well focused package, any shift of public providers to the private sector, or even of shift of clientiele to the

private sector for other uses or the weakening of the public sector by any other collateral process would reduce the social protection for the poor including for women in that age group. After all in a state like Gujarat, maternal mortality is not amongst the first ten causes of death.

Other Examples of Demand Side Financing:

1. **National Blindness Control Programme:**
   The major component of this programme is cataract surgery. In many states the majority of the surgeries are done in the private sector with reimbursement of costs by the government. The process followed is one of accrediting the centers, than on –pre arranged days, mobilizing the patients to reach the private hospital, then surgery and subsequent presentation of records in agreed format with reimbursement. This has been working very well. There are some specific reasons for this. Both the condition and its treatment is visible and well delineated. There are many not for profit hospitals present and are willing to join in eye care surgery. Reimbursements are often delayed, but since no one is too dependent on this, and the sums involved are not great it does not break the programme. Also the main component of expenditure, the artificial lens is provided free by the government. This is a cashless, provider reimbursement arrangement. It is also worth noting that there is often a huge differential between what is reimbursed by the government and what is charged to the routine private paying patient. The government reimburses about Rs 1000 per eye. The private patient is charged anywhere from Rs 15,000 to Rs 25,000 per eye. This is tremendous savings for the poor, but as planners one needs to know the huge differential that could exist between the cost of services and the price of services.

2. **Janini Suraksha Yojana; Accreditation of Private Providers.**
   In Janini Suraksha Yojana a BPL pregnant woman seeking institutional delivery whether she requires emergency care or not, is eligible to get a reimbursement of Rs 1600 in rural areas and Rs 1400 in urban areas to cover the costs of her transport to the hospital and her treatment. This is excluding the incentive to be paid to the ASHA. Though mainly intended to help with public sector deliveries, where a private sector clinic is accredited for this purpose, deliveries occurring in the private sector can also be so reimbursed. Thus it is a form of user reimbursement demand side financing. ASHAs do not get the incentive if delivery is in the private sector.

3. **Reimbursement of medical expenses under central government health scheme**
   (CGHS) Most health care under the CGHS scheme is provided by its network of dispensaries and hospitals. However for a number of procedures the central government employees is allowed to seek care from accredited private sector institutions and on presentation of bills the user is reimbursed. These institutions include a number of corporate hospitals and the bills therefore can be very high, even for procedures that are available much cheaper in the public domain. That is why one of the mandatory conditions is that a public facility has to certify that such a care is

essential for the patient and that it is not available in the public facility. Monitoring of the scheme is very weak and it has almost become an entitlement.

4. **Deendayal Upchaar Yojana:- Madhya Pradesh:**
This is a form of risk pooling with the government providing the resources. In this scheme when a BPL patient is hospitalized in a public or a limited number of private facilities, a certain sum assured is provided to the hospital. The patient has to be treated free of costs. This is largely provider reimbursement. Private sector units can also qualify, though because reimbursement is adequate only to cover drugs and overheads, many private sector units would not find it useful to participate. Since a BPL patient is anyway to be treated free in a public hospital, this demand side financing of the public hospital may not even be known to the patient.

5. **The Rashtriya Swasthya Bima Yojana in Kerala(proposed):**
This is also a form of risk pooling. Indeed it is built on the central government supported, labour ministry led insurance programme model that has been discussed earlier. The variations that Kerala has proposed for this are:

   a. To open the scheme upto another 20% of the poorest- above the national BPL line, but below the state BPL line, so as to have a larger pool of patients.

   b. To open the scheme upto the above poverty line families also – that is universally. However such families would pay the full premium of Rs 700 per family per year.

   c. To fix the costs of procedures rationally, and thus while it would remain attractive for public hospitals and for private not for profit or start up hospitals, it would not be so attractive for established commercial hospitals which charge much higher.

   d. Get public hospitals quality certified and pro-actively move to see that a large part of the clientiele uses public hospitals. Many of them already are so using it. This would be a form of demand side financing of public hospitals.

   e. Of the payments made to the public hospitals earmark 15 to 30% for payments to be made as incentives to the health care providers, so that they are willing to take the higher load and so that they are incentivized for the large numbers of poor that they are already treating.
   Note however that this is primarily an insurance scheme for risk pooling and the role it plays as demand side financing is incidental. Its use as demand side financing of public hospitals is a Kerala level innovation and it will take some time before the results of this approach can be seen and studied.

Review Questions:

1. Give examples from India of public provisioning and public financing of health care; public provisioning and private financing, private provisioning with private financing, and private provisioning with public financing?
2. What do we understand by the term demand side financing?
3. What do we understand by the terms cashless service, user reimbursement and provider reimbursement? Which of these could go together?
4. What are voucher schemes? what are its advantages and disadvantages?
5. What are the essential features of the Chiranjeevi programme and what are its strengths and weaknesses.

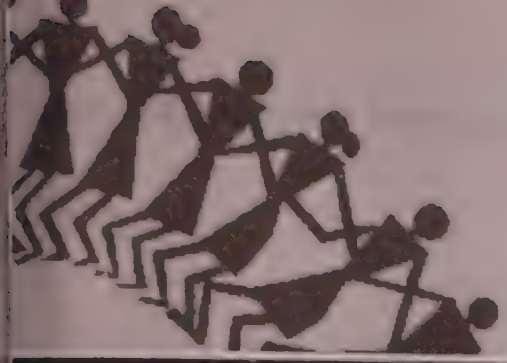
Application Question:

1. Could there be ways of demand side financing which are applicable only to the public sector? Develop up some possibilities using insurance and using direct transfers of funds from the state government to a facility by building on the untied funds to RKS route.
2. If there is to be a demand side package made to fund a private clinic run by a mining company in a tribal area to function as a PHC could one work out the components and the costs? Try to do so- the point is to understand the complexity and limitations of the task. What are the elements of building such a package?

Project Work:

- Briefly evaluate or do a rapid appraisal of a demand side financing in your district and enumerate the strengths and weaknesses. What would you suggest to strengthen it? (most districts would have private providers accredited for JSY or for sterilization or for cataract surgery - at least. Where there are other demand side financing experiments ongoing, prefer to choose them, as these would be well reported by others).

NOTES

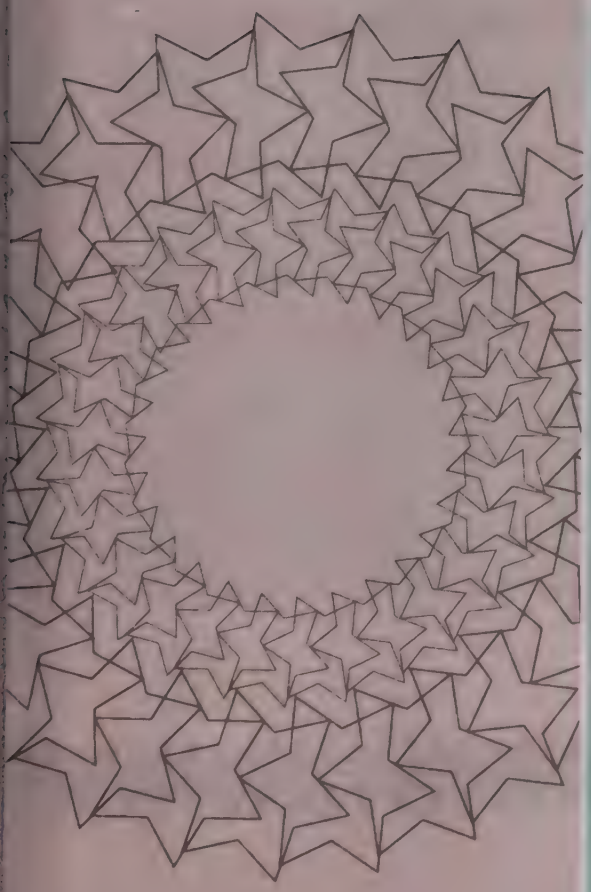


Lesson FIVE

Models of Partnerships in Health Sector

In this lesson we shall discuss:

- Partnership models on the supply side of healthcare delivery
- Assessment of various types of contracting arrangements
- Understanding Social Franchising and Social Marketing models of partnership
- The ideological debates around partnerships in the health sector



SUPPLY SIDE PARTNERSHIPS: OVERVIEW

In the earlier lesson we studied a number of examples where the partnership was primarily an intervention on the demand side. Money followed the patient. Of course this involved inspection, accreditation and almost always (except in a scheme as loose as the Janini Suraksha Yojana) a contractual arrangement with the private providers. These are very difficult to organize.

In contrast supply side interventions seem much easier. Indeed one of the criticisms that are launched against the supply side intervention is that they become a way by which the government is going back on its commitment to provide health services- by contracting out the task. Contracting out of tasks are subject to governance risks and become a way in which private contractors siphon off funds along with provision of kickbacks that corrupt the system. The fear is all the more so because traditionally functions like drug procurement and infrastructure development in which the public sector has always been contracting out to private parties or entering into agreements with – are all areas known to have the highest levels of such risk.

However governments have serious limits in both human resources and in management skills. It therefore makes sense for the government to be able to better utilise and supplement its own resources by a variety of contractual arrangements.

SUPPLY SIDE MODELS OF PARTNERSHIPS FOR HEALTHCARE

We discuss these supply side PPPs under the following heads. The basis of categorisation is just the convenience of discussion of a very large variety of arrangements as there are many overlaps between them:

1. Outsourcing of Key Services including ancillary services and Key Support Functions of the Public Health Facility.

2. The outsourcing of key geographic areas or specific target groups for specific service packages.

3. The facility management contract and the facility lease.

4. The build-operate-run/transfer route for facility creation with special reference to tertiary sector experience.

5. The Social Franchisee approach.

1. **Outsourcing of Key Services of the Public Health Facility or Key Functions of the Public Health System:**
   Below we list a number of contracting arrangements where an ancillary or auxiliary service of a public health facility is given on contract to a private firm.

Examples:

Nature of Function	Contracting Parties	Access to the poor	Assessment
1. Radiological Diagnostics – operates CT and MRI machines	SMS hospital Jaipur and Pvt company	Free for all BPL patients and above 70 years of age.	Assured quality of service: investment by pvt sector, govt pays for services of the poor and provides space. Led to more effective management in a particular context.
2. Radiological Diagnostics- 35 CT machines and 6 MRIs operated.	TNMSC (Tamil nadu Medical Service Corporation) and the public hospital.	Hospital pays user fee for the poor, most in hospital users charged a reasonable user fee and outside referrals charged at higher rates.	The contracted party is itself a government run corporation run on professional lines. For new machines potentially the TNMSC can buy it on bank loans. Average of Only one day downtime in a year per machine Exemption criteria for poor, moral hazards /over use etc not under any monitoring system. Essentially a management arrangement.
3. For all laboratory diagnostics-the facility acts as collection center and the pvt company makes the diagnosis	Bihar State Health society with private company	User fees charged with exemption for poor. In practice very few get exempted.	Samples collected from public health facility and sent to testing site. Poor quality regulation. This system was meant to kick start these services in a setting where facilities also had government staffed labs but were not providing

Nature of Function	Contracting Parties	Access to the poor	Assessment
			services. This it did. The outsourcing also increased the range of diagnostics accessed.
4. Dietary and Kitchen services and Sanitation Services and 5. Laundry services 6. And Security services	These four services are nowadays outsourced almost as the norm across the states-	BPL patients are given diet free of charge – other pay a fixed fee.	Improves quality of diet and efficiency of supply. Better hospital cleanliness and better hygiene. Mechanised laundry established. Management functions of the hospital administration greatly reduced Not clear if as a general model these benefits are seen wherever these are used. Some reports indicate that with respect to expenditure on such items the outcomes are the same. It is perhaps only supervision quality that improves – if at all there is an improvement. Not clear whether equity in employment (labour law safeguards are adhered to).
7. Telemedicine services of the Karnatake integrated telemedicine project	Autonomous GOI body and large hospitals	Since it is a public hospital with universal access, poor can also access this service. But do they? Data is not available.	To provide telediagnosis and consultation for coronary care and other major ailments seen in public health system. It increases access to super speciality care in public hospitals.

Nature of Function	Contracting Parties	Access to the poor	Assessment
			Exact cost benefit analysis studies not available. May have to be examined for impact – since these are relatively high expenditure with limited utilization.
8. Procurement of drugs and equipment and construction of infrastructure. - Tamil Nadu.	State government and an autonomous corporation set up by the government. Though discussed as a PPP in literature, this is better seen as governance strategy.	Dramatic effect on equity. Out of pocket expenditure at public hospital lowest for TN and about 10% of the national average. A responsive system of supply leads to a much higher public health expenditure on drugs.	5% fee charged for all drugs or equipment procured. But as a result it is self supporting and can have professional managers with very high quality output in terms of service delivered. Has led to a much higher level of public drug expenditure which also has a greater health impact and very high efficiencies. Procurement and infrastructure when done on such a scale are professional functions and not part of the core competence of the medical or administrative hierarchy that governs the health system. By outsourcing this area to an institution for which this is a core competence area the entire public health system has been benefitted. Note however that this is a public sector undertaking- so are we talking of PPPs are innovative public sector management?
9. Emergency Ambulance Services in Tamil Nadu and West Bengal and Bihar.	District health society and local NGOs	The NGOs are provided a vehicle and the recurrent costs of a driver. The ambulance is	Flexible work timings, high degree of responsiveness required are not core strengths of the public health administration. However an effective ambulance service

Nature of Function	Contracting Parties	Access to the poor	Assessment
		available on call 24 hours and is allowed to collect user fees to cover its running costs. However for BPL patients, service is free and reimbursed by the government.	remarkably strengthens the functioning of the public health system – impacting both on prevention of mortality and on improved utilization of government hospitals.
10.Emergency Ambulance service – Andhra Pradesh	State health society and a separate not for profit body called EMRI that was promoted initially by Satyam computers- a corporate.	Cashless service- so there is no economic barrier to the poor accessing it. Actual pattern of access with respect to equity not studied and not part of monitoring mechanisms.	. Here the state level NGO has organized for an ambulance in every district at adequate density and it is meant to handle all emergencies. Ambulances can be called by a single phone call – with the same number 180 across the entire state. User fees fixed by the programme can be charged with cashless transaction and provider reimbursement in case of the BPL user._ detailed assessment given in case study below.

The key to these types of contracting out is to be able to define the services down to process details, work out the unit costs of different services and then follow a transparent process of procuring these services. Government rules now allow for such procurement of services.

The problems of drafting an appropriate contract need to be appreciated. Thus it is not enough to ask a contractor "to keep the hospital clean." One would have to specify for example "that outpatient and in-patient toilets must be cleaned every hour during the main working day and at least once in 6 hours thereafter that the floors would have to swept/rinsed etc at a particular frequency etc." From this the minimum number of people needed to do this should be defined and the contract should define both – the minimum processes and minimum manpower that would be deployed. Payment of a fair wage, if not at least adherence to minimum wages and no child labour employment, should also be included.

If contracting done in a manner where quality is assured then it would clearly emerge that the government is saving itself the problems of work force management and supervision and not really saving on costs. The challenge is to keep the function/service delivery viable for the partner agency so that they continue to provide this service. In many of the Bihar PPPs for ancillary services, the costs are fixed so low, that no agency is willing to continue for long and staff turnovers at every level become very high.

In some services like CT scan services and telemedicine services a specialized management input is needed which is costly to provide for each hospital separately – but if put together across a number of facilities works out to be more viable. In such situations there could be savings on costs as well.

In all the above arrangements what is important is a contract or delegating a management function or service provision to an agency whose core competency it is to do that very function. None of the above schemes undermine the public health system- indeed they add to its capacity. None of them replaces existing staff and usually all of these, unlike those listed in the earlier set, do not even under-pay staff as they require a good quality professionals to make each of these schemes operational. Indeed some like EMRI are known to pay higher salaries at every level of the staffing.

The challenge is to provide a professional and independent monitoring framework with effective contract management. so that they continue to provide this service. There should be clarity with each of these contracts as to why a contracting route was chosen to hiring staff within the government and the reason should not lie in lesser salaries.

The PPP with EMRI could be shaped to strengthen public health systems or it could lead to shifting the clientele towards the private sector. In such an instance a policy direction with a monitoring framework is needed. All the above contracts listed are purely forms of strengthening public health services –and cannot even potentially weaken them. They however require a lot of skills in drafting and in 'contract management' to get an optimum result.

2. The outsourcing of key geographic areas or specific target groups for specific service packages.

Most of the current initiatives in this category are contracts with NGOs. There are almost no private commercial providers. Though there is often a process of selection by advertisement and a selection committee – the entire package is pre-determined and fixed and the only assessment made is whether the NGO has the competence and track record to deliver this task. Patronage becomes often the sole criteria – to some extent modified or limited by the organisation's CV.
On the flip side, genuine NGO partners are usually extremely dissatisfied with the process that does not allow them any participation in decision making and treats them as mere implementing agencies and not partners.

Success always depends on how a specific task is defined, and how the NGO assigned the task is involved, trained, supported and monitored.

Nature	Partners	Description	Assessment
1. The MNGO scheme	State Health society and the mother NGO	Each district has an assigned mother NGO which supports three field NGOs to deliver a small package of RCH services. The mother NGO in turn is supported by a regional resource center	Clearly a scheme for not for profit organizations. This is driven by the need to be seen involving NGOs. Often areas chosen are not really underserved and the value addition that the scheme provides is not certain. Duplication with state provided health services is commonplace.
2. The Urban Slum Health Care projects, Andhra Pradesh (indeed all urban slums of Andhra Pradesh). And at Indore Madhya Pradesh, and at Guwahati Assam	District health society and NGO.	Each NGO is assigned a number of slums and is expected to implement a pre-decided programme package in return for an agreed upon sum as reimbursement.	Programme limits itself to very small package of services. Monitoring weak. Substitutes the development of institutional design for urban health care delivery. However in today's slum situation some guarantee that at least some part of the services reaches.
3. Targeted interventions under HIV control programmes.	NGO and state AIDS control society.	To reach HIV awareness messages and to reach condoms to specific target groups which have a higher risk.	Dealing with such defined audience groups- like sex workers or is not a strength of the department

Nature	Partners	Description	Assessment
4. Microscopy Centers/ DTUs under the RNTCP programme.	NGO and district health society	To provide microscopy services in their nursing home and for referred patients/ clinics	
5. Gender Resource Centres, New Delhi	90 NGOs at sub district level have been organised into 73 GRCs in the 9 districts of Delhi, placed under a 'district resource centre' (DRC). Each GRC caters to I lakh population. (the GRC was initially started as part of the stree shakti programme and the bhagidari programme) A variety of services are delivered including outreach, information and redressal	Aim to facilitate the implementation of a set of 45 schemes and services under 'mission convergence' through a 'single window'.	The process is in the early stages. As with no. 2, there is potential of genuinely underserved areas such as 'unauthorised' slums to be guaranteed some services through this mechanism
6: Mobile Medical Units Sunderbans West Bengal, Uttaranchal Mobile hospital and research center, Bhimtal. Also In states of Orissa, Chhattisgarh, Madhya Pradesh.	Mobile health services in Sunderbans West Bengal And mobile medical units in many states.	Provide clinical and diagnostic services in hilly or swampy areas which are otherwise difficult to access and regular services have not been possible to provide- or in addition to regular services	Same as for emergency Ambulance services.

We find that in many of these quality and quantity of services is easily monitored and that all of them involve government paying for the running costs at rates similar to what they would have paid for if they had run these services themselves. However in the first two options- MNGO and urban slum projects- the government seems to be exploring ad hoc cost cutting options for a very limited and often symbolic provision of services. Either these services would have to be expanded into a more meaningful package with corresponding provision for more human resource or a public health structure similar to the one in rural areas should be put in place. In the other four examples either the choice of target group or the difficulty of access to a specific geographic context or a specific skill gap in a given area makes it difficult to build a separate management arrangement to look after that gap in the public health service. Thus these four are complementary and strengthen public health systems- whereas the first two have the potential to become low-cost, low-effectiveness, substitutes of an adequate public health system. The sixth offers an example of facilitating community participation in government programmes while simultaneously providing a service of outreach.

2. The facility management contract and the facility lease.

This is one of the oldest PPPs to be proposed and implemented. Though there are good success stories, it never became a replicable model. We give below a few ongoing examples.

Nature	Partners	Description	Assessment
1. Contracting out of CHCs/ PHCs in Gujarat	NGO, or a specialist couple or an industrial house.	Agencies that are able to bring in specialists (e.g. a husband and wife specialist team) or which are able to bring in money (industrial house) are given the CHCs or PHC and in one case a district hospital on contract.	Potential for replicability limited due to lack of such motivated individuals or groups. Industrial houses managing PHCs has never worked for it's not their core competence or priority and they tend to underestimate the management inputs needed. Equity indicators not in place.

Nature	Partners	Description	Assessment
2. Contracting out of CHCs/ PHCs in Arunachal Pradesh.	Karuna Trust, VHAI and Prayas three NGOs seen as playing leadership roles in the NGO sector have signed MOUs with GOI/ Govt of arunachal Pradesh. Similar MOUs were made in Bihar and Karnataka also	No user fees are charged in Karnataka. The NGO is paid a lump sum amount equivalent to what the government would have been spending on the facility.	Personally handpicking and supporting the staff and a better quality of supervision seem to be the main value addition. Processes like community involvement which often lost in govt programmes regain emphasis. Since the NGOs are handpicked leading NGOs it is uncertain whether NGOs with less national clout to be able to negotiate supervision at their terms would be able to survive. Replication may thus not have the quality that these initial models have – though these are done as models for replication.

These contracts do involve the transfer of public assets to private hands. However to the extent that user fees are banned or limited – they become a management contract rather than a commercial transaction. Thus even the selection is not based on commercial bidding but purposive.... based on the track record and reputation of organizations.

In all these examples, access to the poor is assumed because it is universal and free of user charges but not monitored. Cost and quality control also is assumed but not monitored. Given the reputation of the parties it is reasonable to believe that these would be maintained. But while scaling up the lack of systems for both selection and monitoring would become the central problem. There is also no monitoring regarding labour conditions.

There is also no weakening of the public health system at the present scale of operation and the present approaches which are prioritising difficult to reach areas. This could change if the organizations are

allowed to bid for a chain of facilities and the bidding is made on the basis of lowest quotation for facilities in prime locations.

At this scale of operation, there are advantages to be gained if these institutions can act as bench mark institutions for the rest of the system. But so far even such a limited role has not been realised. However to the extent it allows motivate NGOs and individuals to participate in public health systems, it must we welcomed. As a commercially viable enterprise for private commercial players to enter, there is no demonstrated potential.

4. The build-operate-run/transfer route for facility creation with special reference to tertiary sector experience.

There are number of PPPs where a private company is given the contract to build a tertiary care center and for this they are provided a grant that could run into cores of rupees. Sometimes what the government provides is land which is publicly acquired and provided free or at highly subsidised rates. Often corporate hospitals do not get cash grant or land grants but get exemption on customs, duties etc. Sometimes a built up hospital is handed over to a private company.

The private company is allowed to charge user fees at market rates and run the facility on commercial lines. In return for this the governments gain is

a) that a tertiary care service or medical college is established in that areas

b) that some percentage of patients or some category of patients is to be given treatment free of charge or at subsidized rates.

Such PPP arrangements seldom work for the poor. They do help a tertiary care institution come up but at market rates. Because much of the investment is from the public fund and in grant form there is a tendency to over capitalize and go in for much less efficiency in operations. There is also no way of monitoring the commitment to free service – and this free service quota is usually used up in providing free service to employee families and to the families of influential people.

Example – Endoscopy services in Chhattisgarh: The state government entered into an MOU with a private reputed nursing home in Delhi for the provision of gastroendoscopic services. A sum of about Rs. 3 crores was transferred to this agency which they used to build up the facility and equip it. The ownership of these assets was with the government but the private party had the rights to operate it. Given the expected work load probably much cheaper and less investment of equipment was called for. As it was the endoscopist did not join and the services never materialized. Free services for the poor were an even more distant goal. If the investment had been by the entrepreneur and based on a bank loan it is likely that the management decisions would have been very different.

It is possible that the entrepreneur had already got his returns on investment and had no further need to make the center work. The government can potentially take over the establishment – but on the other hand it does not have endoscopists even now – and that had been the primary objective of the PPP.

Many such PPPs exist where the gains are only to the private sector and often it is the corporate sector. The gains to the public are either minimal or with very poor cost effectiveness as compared to other forms of investing that money within the public health system. Given the high numbers of such PPPs there is considerable justifiable scepticism when PPPs are discussed.

SOCIAL FRANCHISEE APPROACH

This is another approach to supply side intervention – which is not a contracting out arrangement. Here one agency – non-governmental or quasi governmental – decides to start a chain of providers. This can be done by making an existing health care facility into a franchisee or by encouraging a new individual/ group to set up a health care facility. The franchisee has the right to use a brand name and indeed has to pay a fee to use it. In return the franchisee gets a higher number of clients due to the brand name being popularised and also gets technical support to ensure that his or her unit is viable.

Franchisees work best in very specific product or service outlets – for example in ice-creams we have franchisees by Kwality, Arun etc. In fast food restaurants we have MacDonald's, Nirulas, Domino's Pizza etc. In computer education we have NIIT, APTECH, AISECT etc.

In a social franchisee the attempt is to present a set of socially important services as a franchisee operation. The leading and perhaps most successful example of this is the Janani programme which is operational in Bihar and Jharkhand. The products of the Janini franchisees are the entire range of RCH services- but especially institutional delivery, emergency obstetric care, safe abortion services and family planning services. The programme uses the network of RMPs in the villages to provide first contact care services of a very uncertain quality plus to drive in referrals for the secondary care services to the *Janani* chain of hospitals. In return for paying a fee to become part of the social franchisee chain, the private hospital is assisted to reach a certain level of quality in service delivery, The services are reasonably priced but are set against commercial considerations – and hence they are out of reach of the poor unless they are combined with some demand side financing or insurance option. *Janani's* chain is a mix of existing providers who are recruited into the chain and a number of hospitals owned by it which they have started.

The Merry-gold Programme: **Hindustan Latex Family Planning Promotion Trust** (HLFPPT) – a public sector undertaking has been contracted to start a chain of 30 bed hospitals in Uttar Pradesh on similar lines to Janini. This is part of a proposed 770 hospital chain that is part of the USAID supported plans for PPP in Uttar Pradesh. This chain is called the Merrygold chain. It is perhaps too early to evaluate this

model- but we note that the rate of opening up of the chain has been slow because of the structural problems it is encountering. The 30 hospitals created so far are not in under-served areas or reaching to underserved communities. The advantages over public provisioning are far from clear especially when the HLFPPT is itself a public sector undertaking.

Many of the plans for social franchisees are in expectation of demand side financing options or insurance options opening up. The thinking seems to be that today the growth of health insurance is limited by the lack of reliable rate and quality regulated health care providers. A social franchisee chain could be a way of creating such a chain of providers. Its administrative costs would be high but less than that of universal insurance. The social franchisee linked to demand side financing is a potential form of PPP but except for the Janini chain linked to sterilisation surgeries, there is no other model that has proven itself.

Social marketing is a variant of this where the products are branded and one can brand outlet stores too. Yet another franchisee effort is to make IUD services available through a franchisee chain in linkage to the promotion of other temporary contraceptives. Social marketing is another major area where public private partnerships are being tried especially for the greater availability of temporary contraceptives.

CASES OF PARTNERSHIP IN THE HEALTH SECTOR

Case 1: Emergency Response Services

Description of the Scheme:

This is one of the most promising PPPs that have emerged in the last few years and this is presently operational in some of the states. This is a partnership between the state government and the EMRI (Emergency Management Research Institute) which is a non-profit partner that was backed by a big corporate.

The partnership entails provision of Emergency Response Services (ERS) to police, fire and medical emergencies, including pregnancy cases.

The goal is to reach an ambulance, in response to a medical emergency, within 40 minutes in rural areas and 25 minutes in urban areas and provide stabilisation services, even as they are transported to the nearest hospital equipped to manage that emergency. For hilly areas, the EMRI identifies the nearest motorable points, from where they will pick up the patients. The EMRI also assists the state govt. in accreditation of hospitals who can provide various levels of emergency care and who then get enlisted with the agency where they bring the emergency patients. Both public and private hospitals, with minimum facility for emergency care, can be empanelled under the scheme. To strengthen the hospital level emergency care, the EMRI arranges for training of government medical officers and

paramedical staff. The Ambulance services are provided free of cost to patients. The state govt. undertakes to finance the scheme- which includes providing the agency with the funds to buy and equip all the ambulances, and the costs of operating it and the costs of publicity. It is the responsibility of the agency to be responsible for transportation of the patient and "in-transit" stabilisation of the patient. The empanelled hospitals are contracted with the EMRI and are responsible for stabilisation of the patient free of cost. After stabilisation, it is the patient/attendant's choice whether to stay in the same hospital for further care or to shift to another hospital. The transportation for shifting is currently not provided by the EMRI.

Under the scheme, the EMRI is contracted for a period of five years. The specifications for the ambulances (Basic Life Support – BLS, and Advanced Life Support – ALS ambulances) are provided by the agency. The ambulances are bought by the agency. The government also provided the EMRI with the land and infrastructure to set up the state specific call centre to service the emergency calls and direct the nearest ambulance to pick up and take the patient to the nearest empanelled hospital. The software (GIS based) is provided free of cost by the EMRI. The government also provides a toll-free telephone number- 108- for the emergency calls applicable throughout the state. The number of ambulances is inducted into the scheme in a phased manner, introducing more numbers in the districts over the period of the contract.

The scheme has a separate state level committee to supervise the operations of the scheme and they also have full access to the books of accounts and other operational records. The scheme is designed to run on a no-profit-no-loss basis. The financial liability of the state includes the full capital cost of around Rs.25 lakhs per Ambulance and 95% of the total estimated operating cost of around Rs.9 lakhs per Ambulance per year (i.e. Rs.8.55 lakhs per Ambulance per year borne by the government). In addition, the cost of promoting the scheme is also borne by the government.

The PSP has to report to the state government in the form of daily (operational), and monthly (administrative and financial) reports, and quarterly (fund utilization) statements. Also, the PSP has to maintain separate financial accounts and records for the scheme in the state. As per the contract the state government is also bound to provide legal protection to staff engaged by the PSP for the purpose of emergency transportation and care under the scheme.

Current Status of the EMRI:

The EMRI has achieved the status of the largest ERS system in operation in the country and also as being the largest PPP in financial terms. Over 450 crores have been paid to EMRI and the sanctioned schemes have a total value of almost 4000 crores.

Table 1: EMRI in various states of India

State	Launching Date	Status
Andhra Pradesh	April 2, 2005	652 ambulances covering the entire state with 100% population coverage
Gujarat	August 29, 2007	402 ambulances throughout the state with 100% population coverage
Uttarakhand	May 15, 2008	90 ambulances covering entire state with 100% population coverage
Tamil Nadu	September 15, 2008	172 ambulances covering 18 of 32 districts , and 62% of the population
Rajasthan	September 20, 2008	100 ambulances covering all 33 districts but only 21% of the population- largely urban
Goa	September 5, 2008	18 ambulances covering 100% of the state
Karnataka		150 ambulances covering 17 of 29 districts and 72% of the population
Assam		83 ambulances covering 12 of 28 districts and 50% of the population
Meghalaya		15 ambulances covering 2 of 7 districts and 41% of the population.

Source: EMRI documents: Annexure A-16: National Performance Report, dated Feb 17th 2009,

Assessment of the EMRI:

Strengths:

Providing an essential service where none existed before. The fact that a medical emergency can access transport within 40 minutes anywhere in the state and without any payment being "in a guaranteed manner," is a tremendous advance for health rights.

The quality of service is thought into and appropriate protocols and systems for training the providers

are in place and functional.

Supplements public health system: As more sick patients reach the public hospital there is pressure to improve their performance.

Cashless service to the user means that potentially there is universal access- and the poor can access it. This is fully paid for by the government.

Payments to the provider have been prompt and with dignity. The fact that it is backed by a very eminent board of directors and its promoter – Satyam- was a corporate with very high credibility helped.

The providers are paid well- indeed higher that corresponding salaries- in the public sector. However given the greater responsibility and the work loads, these higher salaries may be merited. Certainly the case for the PPP with EMRI is not argued as a cost saving measure.

Limitations and Cautions:

- The entire costs and quality monitoring system is left to the provider. The information provided by the agency is the only source of information for making payments and even this information is not supported by any means of verification. There are no efforts at independent validation of the data.
- Contract management measures are weak. Thus there is no implication in contract for non-adherence to time of response (20 minutes in urban and 45 minutes in rural areas) not clearly defined. Determining nearest motorable point by PSP may not take into consideration the users' perspective. Providing free services to "all" cases means an incentive to the operator to minimize the cost by attending to urban and easily accessible cases, at the cost of equity. But there no mechanisms to oversee any of these aspects. Final say on all these issues are left to the provider.
- The financing of the PSP by the govt. against statements of claims will not help know the actual costs incurred. There is thus no way to test the no-loss-no-profit contention There is no provision for ensuring that services are provided with efficiency and there is full utilization of capacity. Current costs may be about Rs 15 to Rs 20 lakhs per ambulance per year. But there could be savings made even in this. There is no incentive for the agency to improve its efficiency, for whatever its claims, the government is committed to paying it. Thus one of the critical concerns about PPPs which involve transfers of large investments into private hands is the lack of any incentive to increase efficiency. This is very much a feature of this PPP for whatever the EMRI's claims, the government is committed to paying it.

- The operating cost to be reimbursed by the govt. to the agency is constant throughout the contract period and does not take into account the fact that operating costs will be higher in the initial phases, as compared to later phases, as lesser number of ambulances will cater to the same population and geographic area in later phases.
- Equity of access requires monitoring especially as it is government funded. Thus though poor could access it too, do they have the awareness to do so, and are they able to get the same response from the system are questions that independent monitoring and evaluation must track. Potential conflict of interests – for example patients being rushed into select private clinics through informal tie-ups need to be guarded against. Public sector utilization also needs to be improved upon – at least monitored to know what is happening.
- Protection guarantee to PSP staff has not been matched with corresponding service guarantees. District level Advisory Committees could have been an appropriate forum for redressal of grievances vis-à-vis EMRI operations in the district.

The EMRI model is now being more cautiously looked at after the arrest of its main promoter- the head of SATYAM company on serious allegations of fraud. Though as of now, EMRI does not seem to have been a part of the corporate fraud, the need for independent monitoring gains urgency after this development. What such independent monitoring would show is on open question, though if popular opinion is the guide- this model is doing very well.

Case 2: Contracting-out PHC

This is a very common model of PPP that many state governments are trying out with varying degree of success, especially under NRHM. In one of the good performing models, a well known NGO, Karuna Trust, had been contracted out some identified PHCs, along with the Sub Centres reporting to these PHCs, in a southern state.

The PHCs selected were performing sub-optimally, as per basic health and performance indicators. After a series of consultation with the local community, Panchayat and the local administration, the PHCs were handed over to the NGO, along with the land, building, equipment and furniture, in the existing condition. The contract period was initially for a period of two years, which was later renewed to three more years.

The government staffs of the PHC and the Sub Centres were given the option to either join the NGO and remain posted at their present locations or remain with the government and get transferred to another location. Some staff did join the NGO, whereas most of the staff had to be hired by the NGO for running the PHC and its Sub Centres. The government paid the NGO 75% of the total salary amount that the government run PHC and its Sub Centres were incurring. Rest of the amount for salary is borne by the NGO from its own resources. In addition to the salary, the government paid the

NGO an amount of Rs. 25,000 per month for administration and drugs. Currently, the government is paying the full cost of running the PHC and it's Sub Centres (Rs.8 to 10 lakhs), based on satisfactory achievement of the performance indicators by the NGO run PHC.

Apart from routine reporting by the PHC, as per the government reporting formats, the NGO also undertakes community monitoring, thereby building in community involvement in the management of the PHC and the Sub Centres.

Major Issues

- In order to ensure availability of all the required drugs and also to retain skilled staff, the NGO had to invest a substantial amount of money on its own. The NGO also had to undertake capital investment in terms of civil works, renovations and equipment repair and procurement. This particular NGO, being an old and renowned organisation, had various sources of funding to meet the funds required for the PHC, but this might not be the case with most of the NGOs working at grassroots level.
- The PHC was able to function effectively in the area because the "package" included both the PHC and the Sub Centres reporting to it. Transferring only the PHC to the NGO while retaining the Sub Centres would have created problems in reporting, supervision and logistics.
- The PHC had to face difficulties with the Private Nursing Home at the Taluka Head quarters, which felt threatened as they feared losing business. Some of the previous staff of the PHC also joined in creating trouble for the NGO managed facilities.
- The NGO run PHC also had to cope with delays in receiving funds and facing discrimination from the government vis-à-vis other government run PHCs.

The Ideological Debate around PPPs.

The issue of PPPs has always been enmeshed in an ideological debate. Though there many viewpoints we shall simplify these into two polar positions that occupy the two ends of the political spectrum. This would help us understand how perspectives shape not only our perception of the need for PPPs, but also how they read "evidence". We shall call one pole the neo-liberal position and another we shall call the Alma Ata position. We could have also called it the socialist or social democratic position or as the WHO approach, which it was up to the eighties or as the Beveridgean approach.

To those in the neo-liberal ideological position, the best force for economic and social organisation is the markets. The worst force is the government. It follows that government should be small as possible, taking care only of those health activities which are not commercially viable- due to their having high externalities. Governments could also take care of improving access to health care of the poorest, but in a way where the private market in health care is not adversely affected.

The main argument for PPPs from this ideological position is that the public sector is inefficient and will never deliver. According to this view service providers under public administration would remain poorly motivated, because more work or better quality of work is not rewarded. Markets reward good performers better as well as allocate resources more effectively. There are issues like getting doctors to stay in rural areas, that public systems are unable to solve which adds to the weight behind these position- though it is not clear how PPPs would solve it also.

Yet another reason given against public provision of health care is that the poorest 20% of the population benefit from only 10% of the public expenditure on health care, while the richest quintile receives up to 34% of the benefits. So the argument goes that "universal access approaches" to the public health system do not reach the poorest and should be replaced by targeted approaches. (However to the poor, access to public health systems may be their only access to health care – especially hospitalization – whereas for the rich this may be a small part of their health care consumption – or just another cheaper option).

Given these problems and therefore we should push for PPPs irrespective of the problems encountered. Also it would be argued that the cost of provision of care and the out of pocket costs taken together are so high that it is cheaper for the public sector to reimburse a patient seeking care in the private sector than to provide it free in the public sector. The goal is to therefore achieve a situation where health care is provided by largely by private providers, and government becomes a purchaser, buying services from the best providers for the poor and those for whom the government needs to take responsibility.

In the ideal world of the neo-liberal market fundamentalist, the government needs to only procure the services of an insurance company by tendering process and pay the company the premiums for the poor. The company in turn would advertise and accredit various service providers and provide insurance coverage to the poor and to others who voluntarily subscribe for the scheme. The neo-liberal concedes that there are many problems with designing and costing service packages that could determine how much payments should be made by insurance companies to providers and by governments to insurance companies, but these were really technical problems that more management skills would solve.

In contrast the Alma- Ata based World Health Organisations vision was of comprehensive public health systems where the government is the main provider of health care services, with the private sector at best having a supplementary role. This was also known as the district health systems model. This has been also called the Beveredegian approach. In socialist countries, it is known as the socialist approach. The votaries of this approach point out that

a) That markets are not effective mechanisms of allocation when it comes to health. (This is a position that liberals, social democrats and socialists all agree with it. The socialists on the left would argue that markets are not effective for all social sectors and even for economic development.)

b) That the problems of the public health system can, potentially, be solved, whereas the problems of regulating the private sector are much daunting.

c) that even if a system of private provisioning and public financing was desirable, it would be far too costly for any developing nation. A nation like India would have to build its public health strategy around a strong public health system with the private sector playing supplementary roles.

In relation to PPPs the argument is that there is no evidence on record that private sector provides services more effectively or efficiently. The individual health care seeking experience of well-to-do decision makers who prefer to go to private sector hospitals is a poor guide because they can afford special care within better private corporate hospital settings. The average private nursing home is a very cramped space, crowded in by a number of beds, with many under-qualified persons playing key roles. Often in these small nursing homes, there is an AYUSH doctor doing night duty and unqualified nurses providing nursing care. Often the care provided is irrational or even hazardous and prices can be very high and arbitrary –as market forces act very poorly on health care costs.

The comparative cost argument is also contested. If we look at NSSO data (60th round – 2004), the average cost of a non hospitalized ailment is Rs 11 in rural areas in the public sector and Rs 234 in the private sector. For hospitalized care the differential less but it is there. It is about Rs 3452 per hospitalization episode in the public sector and about Rs 7000 in the private sector. Again in such debates the costing of the public health sector is done without taking into account all the diverse functions (preventive, promotive, medico-legal etc) of the public health system. And one does not look at options of improving efficiency of public health systems by rationalizing use of manpower, infrastructure and supplies. Similarly the costs of administering the demand side financing or insurance approaches to private sector involvement or the contractual fee paid to the health care providers in supply side interventions need to be factored in when evaluating PPP options. These could be as high as 15 to 25% of all cost.

There are also genuine concerns about the adherence to basic labour laws in contracting arrangements and often PPPs are cost effective only because it pays nurses and semi-skilled staff less, even going for unqualified personnel to save on costs.

One extrapolation of this position pointing out the general limitations of PPPs could be a position that all PPPs are to be rejected – and condemn all of them as a move towards privatization. This position gets closely allied with a position that in effect insists that the only problems with the current public health system are a lack of investment and that there is no other reform needed. . However such positions, in effect deny the public health system considerable avenues by which it could be meaningfully strengthened and made more accessible to the poor and by which it could be made more efficient in terms of use of public investment and public resources. Such a position also denies scope for meaningful transparent engagements with the private sector which could provide increased access to the poor and gradually lead to a more regulated, responsible and accountable private sector which is willing to subserve public health goals.

The term 'private' also encompasses a vast variety of service providers and is not homogenous. Thus, concerns related to partnering large corporate health care providers, are different from those that apply to partnering with not for profit (but still private) health care providers such as mission hospitals or NGOs. Each type of care provider needs to be assessed for risks and benefits on a case by case basis.

It is through this ideological lens that all evidence on this issue tends to get interpreted. It is not possible to stand outside the influence of these lenses...in some area of neutral objective evidence. However being conscious of the lens we use helps.

The contention is that there are many avenues for meaningfully engaging with the private sector for both strengthening the public health system and for increasing the total investment in the health sector that the poor can access on which there can be a wide consensus. The operationalisation and evaluation of PPPs should be furthered on the examination of each specific option using the principles outlined in chapter 3, to arrive at the right public –private mix rather than commit to increasing PPPs as an objective in itself.

Review Questions:

1. What are the different services contracted out by individual facilities and what are the cautions in such arrangements.
2. What are the issues in replicating the MNGO scheme or the Andhra NGO based slum health services model?
3. Why is contracting out of health facilities not picking up? Is it desirable?
4. What is social franchising? What are the possible uses in the health sector towards achieving public health goals? What are the cautions?
5. How does ideology influence the discussion on PPPs? How would the same evidence be read by persons or groups with different ideological positions on PPP?

Application Question:

- What is the public perception of gains from PPPs for the general public? Do a literature search to find evidence to confirm or refute these perceptions.

Project Work:

- Study a few contracts of supply side MOUs and also study their experience in the delivery of services. How could the contract be improved, and how could the contract be managed better? What would be the benefits and problems and comparable costs if these had been instead been provided directly by the government.

NOTES

Lesson SIX

References, Technical Resources and Further Readings

References, Technical Resources and Further Readings

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Special Contributors to this volume
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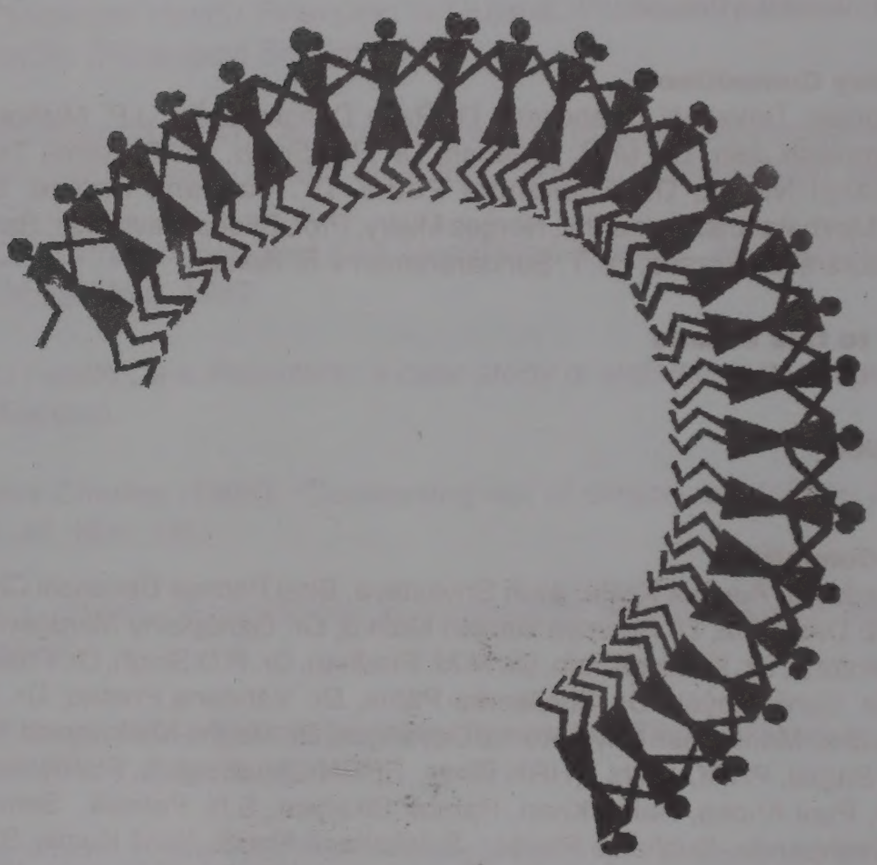
NOTES



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